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ABSTRACT

This document contains witness testimonies from the Congressional hearing called to examine the issue of domestic violence and public health. Senator Hawkins' opening statement recognizes the work of Surgeon General C. Everett Koop in organizing a workshop of over 150 experts in the public health field to examine the problem of domestic violence. Dr. Koop's testimony reports the results of the Surgeon General's Workshop on Violence and Public Health. Recommendations from the working groups at the workshop are included for prevention and for evaluation and the treatment of victims in the areas of assault and homicide, child abuse, child sexual abuse, elder abuse, rape and sexual assault, and spouse abuse. Koop also discusses the role of education in combating violence, the role of alcohol and drugs in violence, and the role of television in desensitizing the public to violence. Other witnesses include chairpersons of different sections of the Surgeon General's workshop. Lee Ann Hoff presents recommendations for the evaluation and treatment of victims of rape, Jean Goodwin examines the issue of child sexual abuse, and Douglas Sargent discusses the prevention of child abuse. Anne H. Flitcraft reports on the prevention of spouse abuse, Jordan I. Kosberg examines the issue of elder abuse, and John Waller discusses recommendations for the prevention of assault and homicide. Also included is a research study on knowledge and management strategies in incest cases which reports results of a survey of 108 physicians, psychologists, and family counselors. (NB)

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S. HRG. 99-443

DOMESTIC VIOLENCE AND PUBLIC HEALTH

ED268439

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

EXAMINATION OF RECOMMENDATIONS PROPOSED TO HELP VICTIMS OF DOMESTIC VIOLENCE RESULTING FROM HEALTH-RELATED CRIMES

OCTOBER 30, 1985

CG 018998

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DOMESTIC VIOLENCE AND PUBLIC HEALTH

WEDNESDAY, OCTOBER 30, 1985

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS AND ALCOHOLISM,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 628, Dirksen Senate Office Building, Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senators Hawkins, Grassley, Metzenbaum, and Dodd.

OPENING STATEMENT OF SENATOR HAWKINS

Senator HAWKINS. Good morning. I must warn you in advance that the Senate is voting, I have been told, every 20 minutes today. So this might be an interrupted hearing.

I am delighted to welcome the distinguished C. Everett Koop. I am a great admirer of Dr. Koop and a Koop watcher. I saw you this morning on the "Today Show." I am also delighted that other members of the public health community are interested and are here today to discuss the report and recommendations of their recently completed workshop on violence and public health. In my mind the basic unit of government is the family. The family unit is the backbone of society, the structure upon which our Government is based, and some families have a dark side.

Traditionally, that dark side is hidden from the public view, and that side includes a disturbingly high rate of homicide, spouse abuse, rape, sexual assault, child abuse, and mistreatment of the elderly.

Growing reported incidences of interpersonal violence are threatening our domestic tranquillity. Violence in the family inevitably moves outside the family unit into society. Individuals who are touched either directly or indirectly by violence in the home are transferring that behavior into their daily lives.

As a society we must define what is acceptable and unacceptable behavior in society. It is up to us to change the social norm so that incidences of violence are no longer tolerated nor disguised. For too long we have accepted the statement that, "We are a violent nation." We do not have to be a violent nation. Violence should not be acceptable in this society. It can be eliminated, and it should be eliminated.

I commend my good friend, the Surgeon General, for convening his workshop for the purpose of charting a substantive response to the ugly facts of interpersonal violence. Last year the Attorney General convened a task force on family violence which made rec-

ommendations regarding action which can be taken in the criminal justice system to reduce the incidence of violence in American families. But violence is not the exclusive province of the police or the courts or the penal system.

The Surgeon General has recognized this and brought together over 150 experts in the public health field to a workshop that was held in Leesburg, VA, this past weekend. I am delighted that this information has just been published, and also we are happy that all the individuals who are committed to reducing the incidences of interpersonal violence are here with us today. Our first panel will consist of Dr. Koop. We welcome you and look forward to your testimony.

STATEMENT OF DR. C. EVERETT KOOP, SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. KOOP. Thank you, Madam Chairman. I am delighted to come before your subcommittee today and to report the results of the Surgeon General's Workshop on Violence and Public Health. I convened that workshop on last Sunday evening in Leesburg, VA, and we adjourned it at 4:40 p.m. yesterday afternoon following 2½ days of intensive deliberations.

We had 175 experts in medicine, nursing, psychology, and social service from all geographic regions, big cities, small towns, and from municipal medical centers as well as from the military services. And together they wrestled to define the roles that their respective professions should assume in order to provide better care for the victims of violence and to prevent violence from occurring in the first place.

It was essential that such a workshop take place. The citizens of our country want to live in peace. They are devoted to peace, and they have a historic veneration for human life. Yet each year an estimated 4 million of them are the victims of violence. And they often are the most vulnerable of our citizens: Infants and children, young women and the elderly.

One of the participants said, "Think of it, the United States is not a safe place for women and children." Madam Chairman, that was a shocking thing to hear, and yet we know from the crude statistics we have gathered so far that over 1 million children each year are abused, some in the most brutal ways imaginable. And we know that as many as 25 percent of all adult American women have been physically abused by a male at least once in their lifetimes. That is almost 15 million women.

No nation that calls itself civilized can live with those kinds of numbers, and no society that values life as much as we do can tolerate this level of human catastrophe. What can we do about it? The traditional response by Americans has been to strengthen the forces of law and order, enlarge our prison capacity, reform our laws concerning the punishment of perpetrators of these kinds of crimes. But we may be compounding our problems in the years ahead.

We know from our experience in health care that a vigorous antismoking campaign, for example, can do more to lower the rates of

sickness and death from lung cancer than any of the most expensive methods of treatment. Prevention is the key to reducing the level of interpersonal violence in American life.

Currently, State child protection service agencies are charged with the responsibility of responding to reports of child abuse and neglect. They investigate all reports, refer situations to law enforcement officials, as appropriate, and provide treatment and services. They also undertake preventive activities. Also, in most areas, programs are beginning to appear to prevent family violence and to provide immediate shelter and related assistance for victims of family violence and their dependents. But it is my feeling that the most effective approaches to prevention in the area of interpersonal violence, and especially domestic violence, could well spring from the disciplines of public health, medicine, nursing, and social service.

That was the basis for my invitation to some 150 experts from across the spectrum of health and health-related professions to come to Leesburg the last Sunday of October. My charge to them was to come forward with a set of recommendations that could be adopted and put into practice by their colleagues in the health professions all across the country.

We know the face of violence. We accept and care for the victims who are beaten, assaulted, raped, and maimed. We in the health professions have tried to patch them up and return them to their homes and their neighborhoods. We have tried to do this in a detached, sometimes even a disinterested way. Some of us were mistakenly convinced that being detached and very clinical about these matters was also being very professional. But we were wrong about that. We would take in a 4-year-old boy whose collarbone had been fractured by a parent exploding in unexplained rage. We patched up the child in the most expert way and then returned him to the same home, the same scene of violence, the same source of pain and unceasing terror, and we were wrong to do that.

We accepted a battered woman in our emergency room, treated the concussive damage of her face and her head, marveled at the dexterity of our personnel, and then returned that woman back to the constant nightmare of her home. The children return with more serious damage the next time. The women will return more severely battered. We have been reluctant to step in and break that cycle of crushing, sometimes lethal violence.

But I believe the health professions are coming to understand that they have an extremely important livesaving role to play that goes far beyond the technologies of medical practice. It is a complicated role, but it is a vital one, nevertheless.

Progress is being made across a broad front ever since the enactment of the Child Abuse Prevention and Treatment Act of 1974. Every State has enacted its own laws requiring health care professionals to report to child protective service agencies any known or suspected cases of child abuse, and increased social services are now available for battered spouses. These are important, lifesaving developments. Health professionals simply do not have the luxury of choice anymore.

As citizens of a humane and compassionate society and as physicians, nurses, psychologists, all bound to the highest ethics of our

professions, and as human beings, we are obligated to provide the best possible care for the victims of violence and to contribute wherever we can to the prevention of violence.

The challenge I placed before the participants at the Leesburg workshop was somewhat new, but it was not totally unknown. Fortunately, a number of excellent academicians, practitioners, and researchers have been exploring this more responsive role for health professions, and it was upon that modest but immensely important body of work that we built the recommendations which we bring before this subcommittee and before the Nation this morning. With your permission, Madam Chairman, I would like to present the full set of recommendations to the subcommittee for inclusion in the record. I would be happy to answer any questions about them later. But I want to emphasize that these recommendations represent the views only of the participants of the Leesburg workshop and are not necessarily those of the Department of Health and Human Services.

Madam Chairman, the United States ought to be a safe place for women and children. It ought to be a good place in which to grow. It ought to be safe for families and for older people, for young black men, for single women, for good, decent Americans living in peace with each other. At Leesburg we offered that as a new and more profound goal for the health professions who take care of our people, and I firmly believe that from this day forward they will accept the challenge represented by this goal. The evidence for my optimism is sitting right here behind me. We have six eminent leaders in health care, medicine, nursing, and research who were among the 11 people who acted as the Chairs of our respective work groups in child abuse, spouse abuse, rape and sexual assault, child sexual abuse, elder abuse, as well as assault and homicide. It was a privilege for me to hear them and watch them over the past 2½ days at Leesburg, and I feel doubly privileged to be in their company this morning.

That is the end of my statement, Madam Chairman. I would be pleased to answer any of your questions about the workshop now or following the statements of my colleagues.

Senator HAWKINS. Thank you, Dr. Koop. We will enter your recommendations from the working groups in the record at this time in its totality.

[The material referred to follows:]

SURGEON GENERAL'S WORKSHOP ON VIOLENCE AND PUBLIC HEALTH

RECOMMENDATIONS FROM THE WORKING GROUPS

LEESBURG, VIRGINIA

OCTOBER 27-29, 1985

ASSAULT & HOMICIDE - PREVENTION

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	Robert Ressler
	Vicki Weisfeld, M.P.H.
	Marvin E. Wolfgang, Ph.D.

ASSAULT AND HOMICIDE/PREVENTION

POLICY RECOMMENDATIONS

Our general policy recommendations are not limited to the health sector. They are so important, however, that they must precede any discussion of more specific measures that involve only the health and public health sectors. In the same way this focus on the health sector recognizes the importance and vital contributions health professionals can make without implying that their potential contributions are any more or any less important than those of other disciplines. We recognize that the Office of the Surgeon General by itself cannot implement all of these recommendations, but we believe that these issues must be an important part of any statement on the prevention of homicide and assaultive behavior.

1. There should be a complete and universal federal ban on the sale, manufacture, importation and possession of handguns (except for authorized police and military personnel); and regulation of the manufacture, sale and distribution of other lethal weapons such as martial arts items (numchuks, stars), knives, etc.

2. There should be criminal penalties associated with the possession of any weapon where alcohol is sold or served.

3. There should be development and implementation of a full employment policy for the nation with immediate attention aimed at the creation of jobs for high risk youths.

4. There should be an aggressive policy to reduce racial discrimination and sexism.

5. We should decrease the cultural acceptance of violence by discouraging corporal punishment in the home, forbidding corporal punishment in the school, and abolishing capital punishment by the state because all are models and sanctions of violence.

6. There should be a decrease in the portrayal of violence on television and we should discourage the presentation of violent role models in all media while encouraging the presentation of positive non-violent role models.

7. The public should be made aware that alcohol consumption may be hazardous to health because of its association with violence.

8. Research the possible relationship among the policy of deinstitutionalization, the lack of adequate community-based support services for the mentally ill and their families with rates of assaultive violence and victimization.

9. Promote communication and cooperation among health care providers, criminal justice agencies, schools and social service agencies to improve the identification of, early intervention for, and treatment of high risk individuals.

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10. Communities should have health care facilities with comprehensive, multi-disciplinary programs that address the detection, assessment and treatment of all forms of interpersonal violence for victims, perpetrators, and their families. Particular attention should be given to the detection and intervention for persons at high risk.

11. We should encourage health education demonstration projects for the family, school and community aimed at decreasing interpersonal violence. These projects should be evaluated for their effectiveness, efficacy and replicability.

12. The education of health professionals should include training in the identification, treatment and/or referral of victims, perpetrators and persons at high risk for interpersonal violence.

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ASSAULT & HOMICIDE - EVALUATION/TREATMENT OF VICTIMS

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ASSAULT & HOMICIDE/ TREATMENT AND EVALUATION

INTRODUCTION

Violence in the United States has become so pervasive that it can no longer be usefully viewed as only a problem of disparate acts by individual offenders. Violence is a public health problem because of the toll it exacts in injuries and deaths, especially among younger people. Too many victims are victimized again and again.

The solution to the problem of violence requires a total community effort but health care providers can play a special role. The emergency room is often the first contact a victim will have with those professionally charged to care. That encounter may determine how well the victim recovers from the emotional consequences of assault as well as its physical trauma. The health care system must help to make victims whole emotionally as well as physically, and help to prevent further violence. Providers must be alert to the special needs of those most at risk of becoming repeat victims.

Our call is for a spirit in America that rejoices in our ethnic variety, a spirit that protects all of our people as our most important resource and legacy and, finally, a spirit that will no longer tolerate violence.

Public health has continually redefined its role so as to address more effectively the changing needs of a changing nation. It is for public health to accept the challenge presented to our country by violence and its consequences.

RECOMMENDATIONS

BUILD A KNOWLEDGE BASE

1. Evaluation and treatment of direct and indirect victims of assaultive violence and homicide requires attention not only to the direct victim(s) but also to indirect victims (families, significant others, observers, communities, care givers).

2. The Public Health Service should support and facilitate collection of data on the direct and indirect victims of assault and homicide who have contact with the health care system. Although an estimated 1.6 million cases of aggravated assault occur annually among Americans over the age of 12, almost nothing is reliably known about the numbers and types of assault victims who receive health/mental health care treatment and the costs of such treatment.

   Specific topics in need of attention include the following:

   a. Utilization of the health/mental health care system by victims of all ages on both a one-time and repetitive basis

   b. Characteristics of the assault or homicide victim(s) and circumstances of the incident

   c. Discrepancies in hospital and police reporting of assault and homicide

   d. Risks for subsequent homicide associated with assault cases seen in emergency services departments

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e. Effectiveness of hospital policies and procedures for identification (and coding), treatment and referral of assault and homicide victims

ENHANCE PROFESSIONAL COMPETENCE

3. The Public Health Service should encourage improved training in the treatment and management of assault and homicide victims in the curricula of schools of medicine, nursing, social work, osteopathy, and allied health professions. In addition, the Public Health Service should encourage the health professions to include questions on violence as a health/mental health problem in state licensure and national Board examinations.

4. Educational programs for those caregivers who may interact with victims and potential victims of abuse must be strengthened to include the particular needs of direct and indirect victims of assault and homicide and their communities.

IMPROVE PRACTICES

5. The Public Health Service should actively encourage the American College of Emergency Physicians, the National Association of Social Workers, the American Nursing Association, and other organizations involved with emergency medicine to review concepts and procedures of emergency care for direct and indirect victims of assault and homicide. Particular attention should be directed to the needs for improved procedures for identification, assessment, treatment and referral.

6. The Public Health Service should assist wide dissemination and discussion of innovative hospital protocols for more adequate care of victims of assaultive/homicidal violence and for the purpose of:

   a. clearly articulating a hospital policy for evaluation and treatment of assault victims that is sanctioned by the governing board and top administrators

   b. developing improved identification, treatment and referral of assault victims

   c. instituting staff training

   d. establishing multi-disciplinary hospital committees to oversee policy implementation and maintain quality control.

7. The taking of a history of victimization or perpetration of violence, establishment of risk profiles, and attention to total health needs should be made part of every examination of direct and indirect victims of assault and homicide.

8. Young minority men of low socio-economic status are over represented among the victims of assault and homicide. Special attention should be given to the adequacy of their health care treatment because they are at greatest risk for repeated victimization and insensitive treatment.

DEVELOP ALLIES

9. A comprehensive community-based approach to the needs of direct and indirect victims of assault and homicide should be encouraged through improved communication and collaboration among health care providers, victim service agencies, community organizations, churches, the criminal justice system, and other relevant agencies.

10. Health/mental health care leaders should support the development of victim assistance programs where they do not exist and the expansion of such programs where they are inadequate. Health/mental health care providers should draw upon the experiences of victim services agencies in order to develop more effective strategies for case management, advocacy, and referral.

11. Health/mental health care leaders should actively enlist the media, schools and community agencies in educating the public about violence as a health problem.

CHILD ABUSE - PREVENTION

CHAIR:	Douglas A. Sargent, M.D., J.D.
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CHILD ABUSE PREVENTION

Education

1. Dramatically increase public awareness of the nature and extent of child abuse by emphasizing that abuse includes not only physical and psychological abuse, but abusive neglect, poverty and other social injustices as well.

2. Conduct a massive campaign to reduce the public acceptance of violence and to protect children against all forms of violence including physical punishment ("No Hitter Day" is one of the many possible techniques - enlist the media's help.)

3. Planning for pregnancy is the starting point for preventing child abuse and other forms of maltreatment.

4. Education and support for parenthood should be widely promoted as acceptable and made available to all parents.

5. Public health departments, public hospitals and clinics must provide educational and support services to parents and families. Included must be cultural/linguistic programs aimed at ethnic groups.

Research

1. Encourage the violence/epidemiology branch of the CDC, to focus on child abuse and maltreatment.

2. Promote studies of what differentiates healthy non-abusive families families from abusive families.

3. Study how various ethnic/racial groups define abuse.

4. Encourage multi-disciplinary longitudinal and cross-cultural research to evaluate the impact of prevention programs on individual children, families, communities and ethnic groups.

5. Encourage the development and testing of explanatory and predictive models of maltreatment causality.

6. Study the impact of changes in public policy on families.

Services

1. Provide vital services to families, including home visitor services, that promote the health and welfare of vulnerable children as a public health priority.

2. Abolish corporal punishment of children in all forms.

3. Provide educational/support programs for prospective and current parents.

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4. Identification of high risk population for service, treatment and rehabilitation of abused children and their families.

5. Alternatives to abusive behavior such as conflict resolution training, anger control, stress management, self-help groups for behavior change

6. Provide linquistically and culturally appropriate services for potential victims of maltreatment through the early identification in the school for those at greatest risk.

7. Provide services to prevent undesired pregnancies.

8. Quality child care that promotes child development should be made available to all.

9. Establish a national public health resource center to train and otherwise assist the efforts of professionals working on the public health aspects of child maltreatment and to work with other child abuse resource centers.

10. Services must be provided to those whom research has shown to be at highest risk to abuse or to be abused. Victims at special risk include developmentally disabled children, runaways, and children of those at high risk to be perpetrators - prison inmates, teenage mothers, parents handicapped by mental retardation and mental illness, substance abusers, parents abused as children, and homeless parents.

CHILD ABUSE - EVALUATION/TREATMENT OF VICTIMS

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	Peter A. Howland, M.D., M.P.H.
	Marie Kanne Poulsen, Ph.D.
	Johanna Schuchert
	George G. Sterne, M.D.

CHILD ABUSE - EVALUATION/TREATMENT

1. For families that abuse, we encourage Child Protection Services and other agencies to expand the continuum of treatment alternatives with special emphasis on both long-term and intensive short-term treatment using a variety of modalities including needed medical services, family supports and parent aides.

2. Professional schools which prepare individuals, who may work with children and families, should adopt multi-disciplinary curricula in the prevention and treatment of child abuse. These curricula should include both didactic (classroom) and clinical experiences as well as use professionals from other disciplines as teachers. Students from diverse disciplines should be brought together during these educational experiences to increase their competency in interdisciplinary cooperation.

3. We recommend restoration of alternatives to Child Protection Services as an entry point for services to children and families (such as visiting nurses, physicians, and other child and family services so that CPS agencies can be relieved of the growing burden of inappropriate and unfounded reports and can focus on serious incidents and risks of child abuse and neglect.

4. We recommend the design and funding of a longitudinal epidemiological study (not less than 30 years) of the nature, causes of consequences of child abuse and the responses to it (e.g. Framingham & Cambridge Studies).

5. Establish standards for the health care of infants and children who are abused to include:

   1) Complete physical and psychological assessment at the time of entry into care, and

   2) Competent and continuous care for the problems discovered in the assessment.

6. Each hospital should have an interdisciplinary child protection team.

7. Establish a multi-professional "commission" system at the local level to assess the potential harm and benefits of criminal prosecution and disposition to child abuse victims.

8. Local, state, and federal agencies should make consistent and co-ordinated efforts to design and fund research and treatment in child abuse from a distinctively public health perspective.

9. Multi-disciplinary continuing education opportunities should be widely available to professionals who work with children and their families. Professionals should be encouraged to take advantage of these opportunities.

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CHILD SEXUAL ABUSE - PREVENTION

CHAIR: Robert ten Bensel, M.D., M.P.H.
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Dodie Livingston
Terry W. McAdam
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Suellen Muldoon
Karin Murray
Robin Rushton
James C. Shine

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CHILD SEXUAL ABUSE/PREVENTION

WRITTEN REPORT OF RECOMMENDATIONS

A. Background Assumptions — Priority

1. Abuse is everyone's business. The health, mental health, economic costs affect all Americans now and in the future.

2. Prevention is directed at both the public and targeted high risk groups for potential sexual abuse.

3. Prevention is both primary (stopping it before it starts) and secondary (early identification and treatment).

4. The first priority must be the protection of the child.

5. Culturally sensitive approaches are to be an integral component in all recommendations.

6. There is a need for American society to realistically confront the phenomena of child sexual abuse.

B. Education

1. Community

a. We recommend an aggressive public education campaign to stop sexual abuse of children by emphasizing that sexual abuse is a harmful criminal act. — 1

b. The public (general public, school systems, religious/culturs groups, juvenile and criminal justice systems), including all subgroups, needs to be provided with the facts about child sexual abuse and the options available for its prevention and treatment. — 2

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Priority

c. Because the sexualization of children in the media/advertising industries may contribute to child sexual abuse in our society. It is therefore recommended that key community, government, public health and media/advertising professionals establish policies and encourage public/private initiatives to set limits on these practices. 10

2. Health and Human Services Professions

Child sexual abuse issues, including prevention and intervention, should be incorporated in the core curriculum for undergraduate, graduate, and continuing education training of health and human services professionals. The curriculum content should be developed by appropriate academic schools and professional organizations. 4

3. Children

a. Educators and public health officials in partnership with parents, should take the initiative to provide all children starting in elementary grades, with well evaluated sexual abuse prevention education programs. This training should include at a minimum knowledge about: sexual abuse; appropriate and inappropriate touching; appropriate and accurate sexual terminology; the right to say no to inappropriate touching; and the importance of telling someone when sexual abuse occurs. 3

b. Educators and public health professionals in partnership with parents, should design and implement well tested programs to teach more effective parenting skills and child development to both elementary and secondary school children to help foster a new generation of parents who are better able to prevent and less likely to perpetuate sexual abuse. 5

c. Primary prevention is a priority. A national search should try to identify, evaluate, highlight and disseminate information about effective sexual abuse prevention programs. 6

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C. Organization and Coordination of Services

1. To improve the identification and prevention of child sexual abuse by encouraging coordination of federal, state, and local programs, policies, and activities at all levels of law enforcement, prosecution, defense, social service, criminal and juvenile justice, public health and other agencies. 9

2. Because runaway and homeless youth are at high risk of sexual exploitation, programs that serve and support them should be strengthened and expanded at all levels. We suggest increased public/private partnerships and increased community-level networking among family and youth service agencies and organizations. 11

D. Research

1. Opening Remark

Research is needed into the incidence, prevalence, predisposing factors, natural history, and the effects of intervention and prevention efforts in child sexual abuse. For example: 7

- evaluation of preventive education programs and
- identification of at-risk children and families.

2. Full Report Recommendations

Improvements in our knowledge and understanding of the phenomenon of CSA as well as more effective preventive and related interventions, require expanded research efforts in the following areas:

a. to obtain more specific knowledge about the incidence and prevalence of child sexual abuse in various segments of the population;

b. to conduct prospective longitudinal studies which document in a systematic manner and to better understand the short and long term effects of disclosed and undisclosed child sexual abuse;

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Priority

c. to identify "at risk" children and families for targeting preventive educational programs;

d. to systematically evaluate the effectiveness of a variety of preventive educational programs;

e. to identify normal sexual development and behaviors in order to identify more accurately deviant sexual development and behaviors;

f. to identify the characteristics of men who are serious and repetitive perpetrators of CSA;

g. to examine the role of parenting behaviors and involvement (and lack thereof) of fathers, as it may relate to their risk of becoming CSA perpetrators;

h. to better understand the effects of disclosure of CSA and involvement of the child victims in the criminal justice system, in order to evaluate procedures for minimizing deleterious effects.

E. Resources

a. Recognizing the limits of our national resources, we recommend increasing federal, state, local and private financial resources in support of effective programs that reduce the incidence of child sexual abuse. It is our judgment that this will be a potent action in both human and economic terms since both lives and money will be saved in the long run. 8

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CHILD SEXUAL ABOSE - EVALUATION/TREATMENT OF VICTIMS

CHAIR:	Jean Goodwin, M.D., M.P.H.
ADVISORY COMMITTEE MEMBER:	Eli H. Newberger, M.D.
RECORDER:	Laurie Pearlman
PARTICIPANTS:	Jon R. Conte, D.S.W.
	Bruce Cushna, Ph.D.
	Marlene Echohawk, Ph.D.
	Henry Giarretto, Ph.D.
	Ellen F. Greenberg, Ph.D.
	Charles F. Johnson, M.D.
	Sheldon Levy, Ph.D., M.P.H.
	Clare Marie Rodgers
	Sandra Rosswork, Ph.D.
	Marti H. Speights
	Joyce N. Thomas, R.N., M.P.H.
	Martin Wasserman, M.D., J.D.
	Bruce A. Woodling, M.D.

CHILD SEXUAL ABUSE--EVALUATION AND TREATMENT OF VICTIMS

RECOMMENDATIONS

Organization of Services

I. Victim and family assessments should be done by trained, multi-disciplinary teams of health and mental health professionals. Members of such designated teams should be considered experts for legal purposes. Assessments should be done using standardized protocols for four axes: physical status, mental health status, family and environmental factors, and investigatory/legal situation. The California protocol for the physical examination is a model in this area. This document specifies facility standards, forensic tests, and laboratory tests for sexually transmitted diseases (and contact testing when positive). As more research data become available, model protocols can be developed for the other axes of assessment. The primary goal of assessment should be treatment and intervention planning for victims and families. Assessment teams should refer clients directly to community resources. Each community's assessment system should minimize the amount of re-interviewing, re-examining, and re-traumatizing of child and family. Standardized forms, one-way mirrors, designated examiners, videotaped or audio-taped interviews, photographs, and coordinated, scheduled assessment visits are suggested as means to achieve this goal. The number of professionals directly interviewing the child should be kept to a minimum. Ideally, each disclosure should lead to only one assessment before a treatment plan is created. Consultations and second opinions should be rendered, where possible, on the basis of review of documents and discussion with prior interviewers without re-examining or re-interviewing the child. The assessment process should consider the possibility that other members of the household have experienced childhood sexual abuse or other forms of family violence.

2. Specialized, comprehensive intervention should involve helping the entire family and/or substitute family to gain an intellectual understanding of the event, acknowledge feelings, explore fears, and distinguish past from present coping mechanisms. Goals should be reduction of symptoms, enhancement of positive, adaptive mechanisms and of individual and family functioning, and promotion of adequate growth and development of children. Treatment for every child for whom it is indicated should begin immediately and continue according to a treatment plan which is rewritten as the child's needs evolve.

3. Regional treatment resource centers should be developed. These centers could provide consultation to underserved areas or difficult cases, organization of self-help groups, gathering of data, training for workers, coordination with regional legal and social service providers, and educational resources.

Research

4. A centralized information point in the DHHS, preferably the Centers for Disease Control, should:

a. assume responsibility for the aggregation, standardization, and transmission of case report information, and for the collection and analysis of violence-related data from such national units as the FBI and the NCHS

b. conduct regular surveys of practitioners, institutions, and the public, with a view to defining and to reporting annually on incidence, prevalence, time trends, and geographic distribution

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5. Data are needed on genital and psychosexual development of normal children for comparison with data gathered from sexually abused children. Genital examination of large populations of normal children should be done to establish a baseline.
Standardized psychological instruments and structured interviews should be tested in children disclosing sexual abuse and compared to control children. Research is needed on symptom checklists, developmental assessments, projective testing, structured interviews using anatomically correct dolls, coloring books and drawings, and structured family assessments. Specialized instruments may need to be designed for use in this area.

6. Research is needed on the short-term and long-term impacts of sexual abuse on victims. Certain high-risk groups could be targeted, including (a) victims who have experienced extreme abuse, (b) those who, on assessment, have severe physical or emotional symptoms, (c) those with minimal family or other supports, especially those who require placement, (d) those with extensive, intrusive legal involvements; and (e) infant or developmentally impaired victims.

7. Treatment outcome research is needed generally, and in the following specific areas:

a. effects of removal from the family of the perpetrator or the victim in intrafamilial cases

b. the efficacy of individual, group, and family treatment in sexually abused children

c. strategies for bringing families of sexually abused children into treatment. Some strategies that should be investigated include legal systems, ombudspeople, and home visits.

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7d. efficacy of various treatments for offenders.

Education

8. Core curriculum in childhood sexual abuse should include strategies for identifying, reporting, assessing, and referring to treatment. This training should be required for mandated reporters, including physicians (particularly emergency room physicians and pediatricians), psychiatrists, social workers, dentists, teachers, nurses, mental health workers, psychologists, and clergy. Law enforcement personnel also require this core curriculum. Professional schools, professional organizations, certifying boards and institutional accrediting bodies can help implement this curriculum.

9. Continuing education and immediate, one-to-one consultation must be available to health and mental health care providers and to the criminal justice system, including those in underserved areas. Those providing direct services should contract an outside consultant to help staff with issues of trauma contagion in order to prevent staff burnout and victim retraumatization. Those working with child sexual abuse need training in and sensitivity to normal child development, to cross-cultural differences, and to the high incidence of abuse among handicapped children. Training in legal and forensic issues is also important.

10. A national child sexual abuse research and information center should be established. The center would provide a computerized data base for child sexual abuse which accesses funding resources, ongoing research projects, active treatment programs, assessment protocols in use in various regions, and available training and educational materials for workers and families.

ELDER ABUSE - PREVENTION & EVALUATION/TREATMENT OF VICTIMS

CHAIR:	Jordan I. Kosberg, Ph.D.
ADVISORY COMMITTEE MEMBER:	Faye G. Abdellah, R.N., Ed.D., Sc.D.
RECORDER:	Frieda Outlaw
PARTICIPANTS:	Amy C. Barkin
	Danny Chin, M.D.
	Barry D. Lebowitz, Ph.D.
	Lee Pearson
	Linda R. Phillips, Ph.D., R.N.
	Karl Pillemer, Ph.D.
	Louis Rowitz, Ph.D.
	Jan Sinnott, Ph.D.
	Suzanne K. Steinmetz, Ph.D.
	Harry R. Tanner, M.S.W.
	Esther Urbano
	Richardson White, Jr.

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ELDER ABUSE/PREVENTION AND EVALUATION AND TREATMENT OF VICTIMS

BACKGROUND ASSUMPTIONS

In our deliberations on elder abuse, we acknowledge the following points:

1. Competent older persons have the right to self-determination.

2. No group is immune to elder abuse; the problem cuts across all social classes, and all racial, ethnic, and religious groups.

3. Most elderly live independently. Others live happily and safely within the homes, or in the care, of others. Many families are heroic in the care they are providing to elderly relatives.

4. Abuse of the elderly can be, in many instances, a result of general ageism in American society.

5. Elder abuse is a part of a larger social problem: violence in contemporary American society.

RECOMMENDATIONS

EDUCATION

1. Develop educational programs that insure that health care providers, social service agencies and criminal justice professionals receive education and/or training in detection, assessment, and treatment of elder abuse.

2. Develop educational programs and materials aimed at increasing the general public's understanding of elder abuse.

3. Develop community education and outreach programs to increase the elderly's ability to protect and care for themselves and adequately use community resources.

4. Develop educational programs on prevention and the occurrence of family violence throughout the life cycle.

RESEARCH

1. Conduct national studies of the incidence, prevalence, dynamics and outcomes of elder abuse.

2. Add items on elder abuse to existing surveys, e.g., health interview survey.

3. Conduct studies to determine the effectiveness of programs for the prevention, detection, treatment, and control of elder abuse.

4. Develop a national clearinghouse for coordinating research, training, and program development in the public and private sectors.

SERVICE

1. Provide services to elder abuse victims that recognize and ensure their rights to live free from abuse (e.g., legal assistance, victim advocacy, emergency and long-term housing.)

2. Develop services designed to assist families to care for vulnerable older persons (e.g., respite care, adult day care, etc.).

3. Develop and expand the capacity of the criminal justice system to respond to the problem of elder abuse in cooperation with other agencies.

4. Develop and expand the capacity of community coordinating mechanisms to address the problem of elder abuse, including case identification, case management, crisis intervention, and communication linkages.

RAPE & SEXUAL ASSUALT- PREVENTION

CHAIR:	Eddie Bernice Johnson
ADVISORY COMMITTEE MEMBER:	Margaret T. Gordon, Ph.D.
RECORDER:	Barbara Parker
PARTICIPANTS:	Judith V. Becker, Ph.D.
	Harvey V. Fineberg, M.D., Ph.D.
	Henry W. Foster, Jr., M.D.
	Philip A. Harding
	Ann Maney, Ph.D.
	William Oltman
	Murray A. Straus, Ph.D.
	Marvin E. Wolfgang, Ph.D.
	Laura X

RAPE AND SEXUAL ASSAULT/PREVENTION

PREAMBLE

Rape and other sexual assaults are brutal crimes with potentially life-shattering consequences for victims and with disruptive effects for society. As a component of the basic right to personal safety, all people - male and female - have the right to control access to their bodies.

Therefore, the following recommendations are offered for the purpose of facilitating society's efforts to reduce and ultimately eliminate these crimes.

We recognize that substantial financial outlays will be required for the implementation of certain of these recommendations. In view of the significance of rape and sexual assault as a devastating public health problem, we urge that adequate funding be made available from both public and private sources to bring them successfully to completion.

RECOMMENDATIONS

The working definition of the workshop was: "sexual assault is nonconsensual sexual behavior that includes stranger, acquaintance and spousal assaults, and male or female victims".

1. We recommend that examination of the definitions of rape and other sexual assaults should be fostered in service, statistical, and legal communities as well as the public at large.

2. Since current research has shown that where women's status is high, rape rates are low, we recommend greater efforts to bring about equality between women and men.

3. In 28 states rape of a wife is now a crime. We recommend that the remaining states and territories also remove the husband's exemption from prosecution.

4. We recommend that sexual assault be clearly recognized as a serious violent crime by all components of the criminal justice system, and that sanctions, including incarceration, should be imposed commensurate with the devastating impacts of this crime on the victim. Prison sentences need to incorporate appropriate treatment aimed at the prevention of further criminal behaviors.

5. We recognize the need for greater public awareness about definitions of rape and sexual assault, facts and myths about rape and sexual assault, impact on victims and their families, the need for crisis services and negative consequences on society of a high tolerance of violence and aggressive behavior.

   We recommend the implementation of specific educational programs targeted to: a) potential victims (especially high risk populations) b) potential assailants (especially pre-adolescents and adolescents), c) appropriate professional communities (to include health care, legal, religious, educational and human service providers).

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6. To maximize the effectiveness of the educational programs cited above. We recommend that research should be undertaken to develop and evaluate the most effective educational campaigns aimed at the prevention of rape and other sexual assaults.

7. There needs to be additional research targeted to:
   a. victims
   b. assailants
   c. situations/conditions in which rape occurs, and
   d. society in general

   (Attention should be given to research designs, instruments, and samples. Topics should include but not be limited to: victim and bystander strategies for rapes in progress and effective/ineffective deterrents; behavioral antecedents of assaultive behavior; successful and unsuccessful treatments for assailants; role of incarceration as a prevention strategy; constraining effects of fear of rape; role of media in promoting attitudes that encourage/discourage sexual assault)

8. We recommend the convening of a conference or other similar forum of qualified researchers in the field of rape and sexual assaults for the purpose of establishing an agenda for future research.

9. We recommend the establishment of a clearinghouse to coordinate and disseminate current information from research, educators, action projects and service providers on rape and sexual assault. (This should include the development of central data bases; and provision of technical assistance).

10. We recommend attention be given to the design and planning of cities, public and private buildings and public transportation areas to reduce the risks of sexual assault.

11. Since current research has established that sex offenders frequently repeat their offenses, we recommend early identification, evaluation and treatment of all sexual offenders, especially adolescents and pre-adolescents evidencing any sexually deviant behavior.

12. We recommend that the media's role in the portrayal of sexual aggression be evaluated as to the public health effects.

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RAPE & SEXUAL ASSAULT - EVALUATION/TREATMENT OF VICTIMS

CHAIR: Lee Ann Hoff, R.N., Ph.D.
ADVISORY COMMITTEE MEMBER: Ann W. Burgess, R.N., D.N.Sc.
RECORDER: Priscilla Kiehnle Warner

PARTICIPANTS: Margaret Long Arnold
Constance Avery-Clark, Ph.D.
Martha R. Burt, Ph.D.
Jane R. Chapman
Fern Y. Ferguson, M.S.W.
Paul J. Fink, M.D.
Shervert Frazier, M.D.
Norman Landsem
David A. Rust
Theoharis K. Seghorn, Ph.D.
Maj. Henry F. Vader

RAPE & SEXUAL ASSAULT - EVALUATION AND TREATMENT OF VICTIMS

BACKGROUND ISSUES

The appropriate evaluation and treatment of victims of rape and sexual assault demands an attitudinal knowledge and skill base grounded in research and experience with thousands of rape victims. This research has revealed that the general public and families as well as human service providers can contribute to the further victimization of rape victims by acting on commonly held myths and biases about rape, lack of knowledge and skill, and failure to accept their role in the evaluation and treatment of victims. An appropriate response implies that the community and its service providers accept these facts about rape:

1. Rape is a crime of violence, not primarily a sexual act, whether it occurs between strangers, intimates or acquaintances. However, one of the effects of victimization by rape may appear later in sexual difficulties and other behaviors.
2. Rape is a criminal expression of power and domination inflicted primarily on women though some victims are men. In contrast, rape is only rarely the act of a psychotic person.
3. Violence is behavior learned from from various sources--the media, pornography, childrearing practices, family violence.
4. Violence must be eliminated as a means of settling struggles and resolving conflict.
5. Women have a right to say "no" and to have their expressions of refusal respected

6. Sex role stereotyping supports the unequal power relations between women and men. Traditional male socialization often limits men's ability to express tenderness; it supports their approach to conflict resolution by violence rather than communication and negotiation. Traditional female socialization often supports passive and submissive behavior.

The knowledge and skill components in evaluating and treating rape victims are defined in existing protocols developed by rape crisis centers, and some hospital based programs. A major issue however, is that these programs exist unevenly in various communities. Therefore, a major goal should focus on the development of such programs as a routine part of every community health facility. This implies a curricula for all health, and human service providers developed by appropriate disciplines and criminal justice personnel through basic preparation programs and continuing education for practicing professionals.

In general, education programs for service providers should coincide with the various entry points at which victims seek help. This includes health facilities, therapists' offices, police, crisis centers, clergy, friends and family.

Since victims may seek help through various avenues and at various stages following victimization, education programs must be broad enough in scope to include those people a victim may contact. Mental health professionals should take the lead here in assuring their own education first (in professional schools and continuing education) and then providing consultation to police, teachers, and other relevant people.

Education programs for the general public will serve to educate health and human service professionals as well. This is an important consideration in planning education programs because many of these professionals hold the same myths and biases about rape as does the general public.

Source materials for such education programs are now available at the Anti-Social & Criminal Violence Branch, NIMH (formerly National Center for the Prevention and Control of Rape), Project SHARE, rape crisis centers and various other community agencies.

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RAPE AND SEXUAL ASSAULT - TREATMENT/EVALUATION

RECOMMENDATIONS

Education

1. Educate consumers of services regarding what they have a right to expect of professional service providers, and conduct a nationwide public education campaign concerning violence, sexual assault and rape.

2. a) Agency - accrediting, certifying and credentialing bodies should incorporate standards regarding evaluation and treatments of sexual assault victims is part of emergency, crisis, mental health services, and the criminal justice system.

   b) Bodies accrediting, certifying and credentialing professionals should incorporate standards regarding evaluation and treatment of sexual assault victims as part of their curriculum requirements and credentialing procedures.

3. Develop clear guidelines and protocols for professionals which include increased sensitivity to aspects of the experiences of victims of both sexes.

Research

4. There should be training programs that prepare professionals to do research in the area of violence, rape and sexual assault.

5. There should be research to explore:

   a) The frequency and associated factors related to rape (epidemiology).

   b) The social environment of rape and sexual assault.

   c) Types and effects of various intervention strategies.

   d) The longitudinal pattern of recovery from sexual assault, including thoughts, feelings, behaviors and general health status. Responses of both victims and her or his significant others should be studied.

   e) The behavior of sexual assailants, including factors associated with assaultive behavior and effectiveness of programs in deterring continued violence.

   f) Strategies and programs needed to change basic attitudes about rape.

   g) Cost-benefit analysis of early intervention compared with untreated victims and perpetrators.

Organization and Coordination

6. There should be adequate public and private support for programs serving victims of rape and sexual assault.

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7. Programs serving rape victims should conform to national standards or various accrediting bodies that define networking and inter-agency agreements to provide various elements of coordinated services.

8. Institutions should provide an ombudsman/expediter for each victim who assists her or him through the process of evaluation and treatment and who emphasizes caring attitudes throughout the process.

9. Technical assistance should be available to communities which are beginning to develop service programs for rape and sexual assault victims.

10. Knowledge about program design, clinical protocols, training curricula, and research results should be available through a central clearing house, e.g., SHARE.

SPOUSE ABUSE - PREVENTION

CHAIR:	Anne H. Flitcraft, M.D.
	Evan Stark, Ph.D.
ADVISORY COMMITTEE MEMBER:	Delores L. Parron, Ph.D.
RECORDER:	Sgt. Jean Albright, USAF
PARTICIPANTS:	Maj. Linda Boone, USMC
	Gary L. Bowen, Ph.D.
	John A. Calhoun
	Karla M. DiGirolamo
	Richard J. Gelles, Ph.D.
	Jean Hilsman
	Janice Humphreys, M.S., R.N.
	Laura Smith McKenna, R.N., D.N.
	Toby Myers, Ed.D.
	K. Daniel O'Leary, Ph.D.
	Lt. Rosemary Pezzuto

SPOUSE ABUSE/ PREVENTION

RECOMMENDATIONS

Education

Problem:

There is widespread cultural acceptance of violence as a means of responding to and resolving interpersonal and marital problems. Historically, women have been the most likely target of family violence. Health care professionals must take the lead in guaranteeing the physical integrity of women.

1. Domestic Violence Prevention Programs should be developed by federal, state and local educational agencies and implemented in educational institutions at all levels. The programs should focus on:

   a. Causes, dimensions and consequences of and responsibility for interpersonal violence;
   b. Relationships between power, control, gender stereotypes, sex roles and violence;
   c. Nonviolent resolution of interpersonal conflicts.

2. National leaders in health care, politics, business, religion, culture and the professions should declare their opposition to spouse abuse and woman battering and develop and distribute appropriate educational materials to their constituents.

3. The Surgeon General should initiate a major media campaign designed to prevent spouse abuse and woman battering. The campaign should highlight that

   a. spouse abuse and woman battering are against the law
   b. the physical integrity of all family members is a basic health right
   c. serious health consequences result from spouse abuse and woman battering
   d. Battering is not limited to any group, gender, racial minority, area or social class
   e. stereotypic male behavior presents potential health hazards
   f. shared decision-making and nonviolent conflict resolution are preferable to male dominance and the use of force.
   g. services are available for abusive adults and their victims.

4. Introduce curriculum on spouse abuse and woman battering into the professional education, training and continuing education of health, social service and criminal justice providers, including clergy, doctors, nurses, social workers, teachers, court personnel, employee assistance counsellors, psychiatrists and police.

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Research

1. Research should identify the factors that contribute to the prevention of spouse abuse.

2. Concurrent research and demonstration projects should be designed to prevent spouse abuse and woman battering.

3. Existing intervention and treatment programs should be evaluated.

4. The different dynamics and consequences of abuse for men and women and the service implications of these differences should be identified.

Services

Problem:

Recognizing that battering has a developmental sequence, early identification and aid to victims can prevent physical, psychological and social morbidity associated with ongoing abuse. The major components of such a prevention program are identification of the problem, protection for the victim, stopping the violence, expanding options and empowerment of women.

1. In health and social service settings, spouse abuse should be uniformly defined as any assault or threat of assault by a social partner regardless of gender or marital status and whether or not they are present or former cohabitants.

2. Support the empowerment of women by expanding their social and economic options before and after the identification of abuse. Areas of inequality that must be addressed include pay equity, the enforcement of child support orders, adequate and low cost housing, child care and job training opportunities.

3. Establish and implement model protocols for the early identification and aid to abuse victims in health settings.

4. Support the development of spouse abuse protocols for use in secondary treatment sites dealing with sexual assault, alcohol and drug abuse, suicide prevention, emergency psychiatric problems, child abuse and the homeless.

Problem:

Child abuse professionals and organizations pay insufficient attention to the well-documented link to woman battering. Evidence suggests prevencing spouse abuse and woman battering would have a major impact on the prevention of child abuse.

1. Federal, state and local initiatives dealing with the prevention of child abuse should be mandated to directly address the problem of spouse abuse and woman battering.

2. The purview of the Regional Centers established under the 1984 reauthorization of the NCCAN and of the National Advisory Board on Child Abuse and Neglect should be expanded to include the concern with woman battering and spouse abuse, renamed to reflect the broader concern for family violence (e.g. National Advisory Board on Family Violence) and its membership extended to this new constituency.

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7. The shelter movement should be encouraged, supported and extended to meet the emergency needs of victims, including protection, housing and advocacy.

8. The Governors should mandate a state office or representative to serve as the focal point in each state for the programmatic and policy response toward domestic violence.

9. Criminal justice policies and procedures should be established to ensure that battered women receive equal protection under the law and to facilitate a swift resolution of these cases and an end to violence. In this context, sexual assault, and specifically rape, should be acknowledged as a crime regardless of the present or past marital relationship between victim and perpetrator.

10. The Congress should address the needs of families living on exclusive federal jurisdiction to assure that they are provided the protection of law in incidents of family violence.

11. Programs should be developed and supported which treat, educate or counsel abusive men to curb further violence.

SPOUSE ABUSE - EVALUATION/TREATMENT OF VICTIMS

CHAIR: Luella Klein, M.D.
ADVISORY COMMITTEE MEMBER: Alan Wurtzel, Ph.D.
RECORDER: Sara Torres

PARTICIPANTS: Carole Anderson, R.N., Ph.D.
Mary Pat Brygger
Jacquelyn C. Campbell, R.N.
Elaine Hilberman Carmen, M.D.
Phyllis Old Dog Cross, R.N., M.S.
Lt. Joseph DiPaolo, M.S.C., USN
Juanita K. Hunter, R.N., Ed.D.
Arnold S. Kahn, Ph.D.
William Modzeleski
Lenore Walker, Ph.D.
R. Dale Walker, M.D.
Barbara Shaw

SPOUSE ABUSE - EVALUATION/TREATMENT OF VICTIMS

PREAMBLE

Spouse abuse includes physical, sexual, and psychological abuse and is found in all social, economic, ethnic and racial groups. Spouse abuse is a crime primarily perpetrated against women that often results in serious injury and premature death and affects the psychological development of children and their families. Spouse abuse is not a private matter and has ramifications beyond the immediate family.

Spouse abuse is rooted in a sexist social structure that produces profound inequities in roles, relationships, and resource and power distributions between women and men in families.

Interventions which blame the victim and do not hold the abuser accountable for the violence are ineffective and inappropriate.

RECOMMENDATIONS

1. A full range of coordinated health, mental health, legal, and social services for victims, abusers, and their children shall be available in every community, supported by a stable funding base.

   a. Services shall include innovative creative treatment approaches to address the specific economic and socio-cultural needs of vulnerable populations.

   b. Interventions shall include strategies that hold abusers accountable for their violent behavior.

2. The number one priority for intervention in spouse abuse is to provide safety for victims and their children through shelters and safe homes and other protective environments.

3. It is recommended that all health professionals receive specific training in the area of spouse abuse.

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a. Information on interpersonal violence including spouse abuse should be a component of the basic curriculum for the education and training of all health professionals — physicians, psychologists, nurses, social workers, counselors, health educators, etc. It also should should be a component of education for teacher, Lawyers, policemen and other groups who work with the public.

b. Information on interpersonal violence including spouse abuse should be a component of post-graduate and continuing education for health professionals and teachers.

c. Certifying, licensing, and state board examinations and credentialing procedures should include questions concerning the subject area of spouse abuse. This would assure minimum knowledge about interpersonal violence and spouse abuse among health professionals and teachers.

d. Standards of practice for the various disciplines of health professionals, e.g., nursing, psychology, social work, health education, and physicians (family practitioners, pediatricians, psychiatrists, obstetrician-gynecologists, orthopedic surgeons, emergency room physicians) should include recommendations for standards of care which include identification of victims and abusers and appropriate intervention and prevention strategies.

4. Research on prevention, causality, treatment and intervention of spouse abuse and family violence should be given high priority, and the allocation of resources for this effort should be proportionate to the extent of the problem as compared with other public health problems. Special attention shall be given to high risk populations and efficacy of existing interventions for victims and abusers.

Suggested topics for research:

a) Longitudinal study of victim survivors
b) Evaluation of intervention models
c) Effective state and local public policies that serve to coordinate and promote model public policies for state legislatures

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d) Risk factors that predict homicide in violent relationships
e) Characteristics of batterers to determine causation of men's aggression against women
f) Models of how abusers stop abusing
g) Relationship between alcohol and substance abuse and frequency, severity, and lethality in spouse abuse.
h) Interaction of personal and environmental factors which serve to escalate abuse
i) The relationship between violence in mass media and spouse abuse
j) Adaptation of psychological assessment tools to measure the psychological impact of spouse abuse and post traumatic stress disorders
k) Relationships between stress-related disorders and spouse abuse
l) Examination of vulnerabilities for spouse abuse in different high-risk populations, i.e., minorities and lower socio-economic groups
m) Long-term effects on providers who work with spouse abuse
n) Characteristics and coping skills of women who have left violent relationships
o) Long-term impact on children who witness spouse abuse
p) Models of prevention of spouse abuse

5. The Surgeon General should develop an informational campaign designating spouse abuse as a major public health problem.

6. Protocols for spouse abuse identification and intervention should be developed and used by health care professionals in all settings such as in emergency rooms, trauma centers, primary care sites, mental health centers, psychiatric hospitals, and physicians' offices.

7. All existing and proposed typologies should be examined to eliminate victim blaming. Consistent with this, we oppose the proposed new DSM III-R psychiatric diagnosis 301.89* Masochistic Personality Disorder, which may be applied to victims of spouse abuse. This diagnosis is victim blaming, pejorative and sexist. It would be harmful and counter-productive to identification, intervention, and prevention strategies.

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8. The Surgeon General shall vigorously pursue adequate federal funding for spouse abuse programs. In particular, there shall be support for the adequate appropriations and distribution of monies to implement the Family Violence Prevention and Services Act.

9. The medical, nursing and social work assessment of pregnant women should routinely include questions concerning spousal abuse, i.e., routine questions on prenatal history forms. A pregnant woman who is abused physically or sexually by her spouse or cohabitant should be identified and the pregnancy classified as high risk. The patient should be eligible for high risk prenatal health care management.

10. Spouse abuse research sponsored by the various agencies of the federal government should be identified, coordinated and the results widely disseminated.

11. While there are examples of excellence in the self-regulation of violence in the mass media, we believe that there continues to be overrepresentation of violence. We urge the development of realistic standards which might reduce the level of violence in all media.

12. Review and change public policies that promote or support spouse abuse and other forms of interpersonal violence.

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Senator HAWKINS. I noticed in the Delphi Survey of workshop participants that there was strong agreement that more research needs to be done on the relationship between alcohol, drug abuse, and violence. Do you have any recommendations regarding that statement?

Dr. KOOP. The recommendations that were put forth by the committee yesterday included such things as the fact that weapons and alcohol do not mix any more than driving and alcohol mix. And there were suggestions that there were areas in which we could do behavioral research in reference to the effects of alcohol and drug abuse as inciting causes of violence.

Senator HAWKINS. What should be the role of education in combatting violence?

Dr. KOOP. Well, there have to be two types of education, Madam Chairman. The first is education of the public and the second is education of health professionals. The public has to be aware of what the problem is, where help can be found, and what their expectation in the best of all societies might be.

But we have then to also affect the attitudes of health professionals who are caring for individuals who are victims and to give them some understanding of the role that they play with perpetrators. For example, one of the most refreshing attitudes that I think came out at the Leesburg Workshop was quite a different attitude toward victims than I think would have taken place 5 years ago. We all have the tendency when somebody has an accident on the highway to say he was driving too fast anyway, or when someone is hit by another person, we say he probably asked for it.

So we have not been very forthcoming in sympathy for victims. And I think one of the things that was quite different at this workshop was the complete sense of compassion by experts as to the plight of victims.

Then when one turns to the other aspect of education of health professionals, it has to do with the fact that there are alternatives to aggressive behavior and the response to provocation by violence. This is where I think we have one of our greatest opportunities—in teaching young people how to deal with aggression. There are programs in various parts of the country, one particularly good one in Boston, where young people in high school act out provocative situations, have it filmed on television, and then sit down and analyze what they did wrong, what they might have done differently to avoid a confrontation that led to violence.

I think that kind of very inexpensive and very interesting program can do a tremendous amount to defuse the things that lead to violence among young people.

Senator HAWKINS. Are there areas that the public and the community need more information about?

Dr. KOOP. Oh, I think the public needs more information about almost everything that we discussed. For example, at the far end of the lifespan is the newest of the abuses, elder abuse. I think that perhaps the most pitiful of all abused people are defenseless, vulnerable, elderly people. We have to make this just as much a part of public education as we have made child abuse.

I think we have to educate people to realize that the kind of injury that comes in an abusive situation is not just a broken arm

or a bashed head, but that there are tremendous psychological and emotional implications. People who have been abused live in households filled with fear and dread. At the same time, they have tremendous feelings of guilt and of shame about what their responsibilities might have been, and then those four emotions are in conflict with the usual emotions of love and loyalty that most people need in order to maintain a family.

So we are not talking about just a fractured bone or a black eye; we are talking about a very pervasive series of sequellae that permeate the entire family in these interpersonal problems.

Senator HAWKINS. Did your committees speak at all to what role, if any, television plays in desensitizing the public to acts of violence?

Dr. KOOP. Yes. I think that television was talked about a great deal, especially the manner in which so many violent programs on television might be used either to start aggressive behavior in young people or to suggest that some of the people they admired most are role models for violence.

But in the actual recommendations that were made to me at the end of yesterday, there were several that asked for continued study of the effect of television on violence. You should know, Madam Chairman, that as long as I have been in this position, I have been escalating my concern about violence, presenting it first to pediatricians and then to academia, and then at a rather historic meeting here where the television industry and those concerned about television violence united with George Washington University and the American Medical Association in a very good symposium.

On that occasion, I called for an end to the bilateral criticism of television and the Public Health Service, and for us instead to work together to look down the road to what we might be able to do to understand why our people are so attracted to violence.

I am happy to say that we have had very high echelon levels of conversation with all of the three major networks, and they have appointed one individual to represent all three of them who is the liaison with my office on this particular problem of violence. And I think that there will be some good things that come out of that in the future.

I would feel remiss if I did not add that dealing with the networks, which are in a sense regulated, is one thing. But my greater concern is dealing with cable television where the regulation is not in place and where the things that I see that are available to my grandchildren to see are things I wish they did not look at.

Senator HAWKINS. Do you have any recommendations about improving the cooperation and coordination among services and disciplines?

Dr. KOOP. Yes. I think that was perhaps the underlying sequel of this entire conference. If those people who function at the intake level of the victim understand what the resources are and how they can become involved with institutions and professions, then we not only are able to satisfy our obligation to the victim, but we can intervene in a family situation and impose a barrier between the perpetrator and the victim by dealing with him in any one of a number of ways. First of all, we can make him realize what his problem is—and I am sure you know that most men, for example,

who batter their wives do it three or four times a year; 30 percent of all women who are beaten are beaten repeatedly. The intervention process is new, and it is one of the things that makes me believe very firmly that this is a public health issue just as much as it is one of law and order. Justice is very important in the apprehension of criminals and their punishment. But as yet they are not into prevention, whereas we are because that is our business.

Senator HAWKINS. This committee favorably reported legislation S. 140, the Children's Justice Act, which clarifies the need to protect children from possible abuse. It takes precedent over privacy provisions. Are you familiar with S. 140?

Dr. KOOP. In general.

Senator HAWKINS. It was felt that violence is not the exclusive province of the police or the courts or the penal system. I wonder exactly how we should treat a situation where a teacher calls me and tells me that she finally decided to report the abuse of a child in her class.

In the trial that followed, the presiding judge insisted that he would only hear the case if the father, who was accused of the abuse, was in the same room during the trial as the abused child. The father came in, the child was traumatized and could not even speak. So the judge dismissed the case. The teacher called me and wanted to know how the Children's Justice Act would have helped in that situation.

What can we say to a teacher like that after she reads the recommendations you have suggested?

Dr. KOOP. Well, I think that we can tell her this is the first Surgeon General's Workshop and not the last, and the next one that I have I hope to be one that is partnership with the Department of Justice in looking at just some of these problems. In various jurisdictions around the country, as I think you are well aware, Madam Chairman, the sensitivities of dealing with juvenile witnesses has been addressed, and one of the recommendations that was made to me yesterday was that when there is the need for a child to be a witness, that the testimony be taken either verbatim or from a court record rather than to expose this child over and over again to the necessity of appearing before different people in the criminal justice system.

I think that many reforms such as that are badly needed and will come as the public becomes better educated about the damage that can be done to juvenile witnesses and how their inability to react to these situations actually slows down the process of justice.

Senator HAWKINS. Are there courses in medical school that teach health professionals how to deal with violence?

Dr. KOOP. If there are, I do not know about them. Certainly violence is taught in pediatrics in reference to child abuse and child sexual abuse, but I think one of the recommendations that came out of all 11 groups yesterday was for changes in the curriculum of medical schools, nursing schools, schools of social work to address this problem as well as to be certain that continuing medical education curricula also cover these problems.

Senator HAWKINS. An area of strong agreement seemed to be that school health facilities should be brought into the violence prevention network and that violence prevention should be taught

in the family life courses in school. What would the courses teach, child safety or how to prevent abduction and abuse?

Dr. KOOP. I think several ways: How to prevent abduction and abuse: teaching children what touching means and when touching is legitimate and when it is not, teaching them, especially the young ones, that they can talk to other people when they find themselves in the position where they cannot trust an adult that is a member of their family.

But those are purely educational procedures. I think the place where school health authorities can intervene, as I mentioned a moment ago, is when they recognize that there is a problem of abuse, that the intervention takes place not only to protect the victim but to now deal with the perpetrator so that that person begins to recognize what his problem is and seeks the kind of help that might alleviate it.

Senator HAWKINS. I have a couple more questions, but Senator Metzenbaum and Senator Dodd have joined us. I will turn to Senator Metzenbaum.

Senator METZENBAUM. First, Madam Chairman, I commend you for convening these hearings. I think it is an issue of major importance to the entire country, and I also want to commend the Surgeon General, Dr. Koop, for his bringing the issue of violence into the context of public health where it certainly belongs, and the fact that you have had a special workshop on violence and public health. I think you are moving very much in the right direction.

You may have already spoken to this issue, but out of that conference, were there some recommendations made, and if there were, which ones have the priority in your view?

Dr. KOOP. Well, the way the conference worked, Senator, was that each of the 11 work groups presented me at the end of the day with recommendations varying from 8 to 27 from each group. We had a tremendous number of recommendations. Some were, of course, duplicative. I think that the major concerns that were expressed in a generic way were that we have to intervene in two directions: One, as I just said to Senator Hawkins, to alleviate the suffering of the victim, but perhaps more importantly, for prevention to intervene with some kind of a barrier against the perpetrator, not just to punish him or to apprehend him as a criminal, but to begin to work on him so his lifestyle and response to aggression is changed in such a way that he becomes a more tranquil member of society.

Senator METZENBAUM. I have a little difficulty in reducing that to its simplest terms. Does that mean relieve some of his economic frustrations? Does that mean to give him psychiatric care? I am not quite certain that I follow what you are saying.

Dr. KOOP. It could mean both of those, either one of them, or that plus something else. It could just be something as simple as being able to teach an individual like that to handle rage or to handle frustration, and to point out how his use of body language, for example, might be considered by another person to be a sign of confrontation.

Senator METZENBAUM. Dr. Koop, I understand what you are saying, but I am having difficulty in translating it into the real world. How do you go about doing that?

Dr. KOOP. Well, let us say that in the real world a child comes in who has been battered and comes into a comprehensive health center, let us say in a hospital. Not only should that child be treated, which is obvious, but then the intervention technique is that you get the psychologist, the social worker, the physician and nurse working as a team to talk to the perpetrator to find out why it happened—whether this man has a pathological personality, whether he is emotionally upset, whether his problems are economic or ethnic or social—and then address that issue. That is what I meant by the network of health professionals working in an institution not only dealing with the victim but trying to produce barriers between the victim and the perpetrator so that it does not happen again.

Senator METZENBAUM. Do you have any plans to implement that kind of program at the present time?

Dr. KOOP. What I plan to do with the recommendations that were given to me yesterday is to disseminate them as widely as possible, and I appreciate this opportunity to begin here. I pledged myself to the conference yesterday to begin that through Public Health Reports, through the Surgeon General's bulletin board, to contact organized medicine, to work through our own areas in the Indian Health Service, various agencies, migrant health, the National Health Service Corps, every place that we can impact upon the care of patients to make this part of their understanding of the health issues in this country.

Senator METZENBAUM. Dr. Koop, I noticed conspicuously absent from your response was the fact that you have not mentioned the business community, the Chamber of Commerce, the National Association of Manufacturers, the Business Roundtable, the AFL-CIO, the labor groups, and because it seems to me that bringing them in, too, might provide for a much more rapid kind of implementation than any other kind of procedures that might be used.

I am wondering whether or not that is part of your contemplated program.

Dr. KOOP. I did not leave them out by intent, sir. I intend to approach the private sector, not only the kinds of organizations that you have mentioned, but also voluntary organizations—everything from 4-H Clubs, Boy Scouts, Girl Scouts, and such—because I do not think there is any segment of our society that could not profit by addressing this issue which affects 4 million Americans a year.

Senator METZENBAUM. Dr. Koop, I commend you for going as far as you have. I think you have made some good breakthroughs, and I just want to say to you, though, that I have been around Washington long enough to know that we oftentimes have committees, we have commissions, we have study groups, and we have lots of other kinds of talk-talk meetings and nothing ever comes about it, and very heavy, thick reports are prepared and put up on a shelf, and there is not any action that results therefrom.

In this instance, it would be unfair of me to say, well, why have you not done something already because you only had the conference conclude yesterday. But I would say to you that I think many of us in the U.S. Congress would very strongly support your implementing the program at an early a date as possible.

Dr. KOOP. Thank you. I would say, sir, in my defense about that that this is—

Senator METZENBAUM. I do not mean to put you on the defense.

Dr. KOOP. No, I understand. But this is the fifth Surgeon General's Workshop I have had, and the results of the other four, which have been on problems of handicapped children and their families, breast feeding, and organ transplantation, have been very successful because this technique does lend itself to rapid dissemination. There is a certain moral persuasion that comes from the Office of the Surgeon General which does give it some cause.

Senator METZENBAUM. Thank you very much. Madam Chairman, I came late and I am going to leave early because I walked out of another committee hearing. But I do very much support your efforts in this respect as well as Dr. Koop's.

Senator HAWKINS. Thank you, Senator Metzenbaum. Senator Dodd, welcome.

Senator DODD. Thank you, Madam Chairman. Again it is one of those days where all committees are meeting simultaneously. My apologies to you, Dr. Koop and to Madam Chairman.

Very briefly, of course this morning we are addressing an issue of tremendous importance, one that the distinguished chairperson of this committee has been deeply involved in and one that I am delighted to see, Dr. Koop, the comprehensiveness of this conference you have had. It sounds to me as though it has been excellent, and obviously, as you have pointed out, no family member, no economic group, social group is immune, obviously, from the problems of physical, sexual, or emotional traumatization as a result of this kind of abuse.

One out of every four American women have been abused by a male partner, according to reliable statistics, and over 1 million children—and by most conservative estimates a child is sexually abused somewhere in this country once every 2 minutes, most often by someone within their home or close to them, not by the stranger, of course, as we all now know painfully.

There are increasing reports of physical and sexual victimization of elderly parents as well, something that I do not think many of us were aware of a few years ago. As I said at the outset, I commend you for holding this conference. It is timely on violence on public health, and as a founder and cochair of the Senate Children's Caucus and as a ranking member of this committee on children, I have spent some time over the last 5 years trying to restore and promote some efforts to combat family violence along with the Federal Challenge Grant Program for children's trust funds especially designed to prevent child abuse. It is now public law, that particular piece of legislation, along with the chairperson of this committe and the full committee, Senator Hatch, we worked to resolve the Baby Jane Doe problem a few years ago to the point where we passed that legislation, I think 92 or 93 to nothing on the floor of the Senate, something none of us imagined would be the case when we started to grapple with that particular problem.

I am also a sponsor of the family violence legislation passed last session and have joined with my colleague from Florida to pass the Children's Justice Act, focusing on the treatment of abused children in our courts. Nonetheless, Dr. Koop, these programs do not

come close to addressing the need of prevention and treatment efforts in communities from my home State of Connecticut to California.

We know the scars of family violence can be severe and very long lasting. In far too many cases such violence produces a final result, of course, death. Thus, I welcome the testimony of our expert witnesses this morning. Having said that, let me ask really only one question of you.

You have pointed out that this is not just a justice problem. You mentioned that Senator Hawkins and I and others, I think, did take a proper step because that is an element of all of this. Obviously, we have to grapple with it. One of the real problems seems to be among colleagues of yours, professional colleagues of yours, physicians, and the reluctance of physicians to report cases of spouse abuse or child abuse.

I wonder if you would comment on that observation. Am I accurate in making that observation? Why is that so? And what could possibly be done to improve the reporting requirements of physicians when confronted with very clear cases of that kind of abuse?

Dr. KOOP. Well, I think you have to separate the child abuse reporting from the reporting of other violence because there are now laws that make the reporting of child abuse mandatory.

Senator DODD. I should have said just spouse abuse. I apologize.

Dr. KOOP. But the other problems I think one can recognize. First of all, I think the trap that many physicians fall into is that this is not going to escalate and I can handle it at this level. Also, there is always the fear of losing one's patient. That could be an economic concern, but I think more often than that it is an altruistic concern. If I get the law into this problem, I am going to lose my effectiveness as an arbitrator and perhaps one who can practice some prevention and keep it from happening again. I do not see that we are going to go in the direction of reporting all of these kinds of abuse in a mandatory fashion.

Senator DODD. Is it widespread, by the way? Do you think it is a problem?

Dr. KOOP. Which?

Senator DODD. The failure to report spouse abuse?

Dr. KOOP. Oh, yes, very widespread. You know, there are a great many myths and misconceptions: a man's home is his castle and unfortunately many men think that what they do behind the doors of that castle is nobody's business but their own.

It is widely accepted, therefore, by people who deal with them professionally. I would rather see us go to the point where physicians realize what an important role they can play not only in the treatment of the victim, but in the prevention of recurrence and the rehabilitation of the perpetrator. If we get enough physicians, nurses, psychologists, social workers thinking that way, then I do not think we have to go toward mandatory regulation. That is one of the things that I think is most likely to come out of the recommendations of this workshop, that we will get the widest possible dissemination.

Senator DODD. I would be very, very interested in seeing some specific suggestions in that regard. I do not disagree with your last comment either. I think it may be self-defeating in some cases as

far as the ultimate goal of improving the reporting requirements, but I am not so opposed to a step in that direction that I would rule it out either.

I would like to think something else might work. I would be very interested in the specific suggestions that you might have and that we might act on in this committee on in the Congress.

Dr. KOOP. We plan an interim report and then a report a year hence to all members of this workshop. I would be pleased to see that members of your subcommittee, Madam Chairman, all receive this report and know what we have been able to accomplish in that time.

Senator DODD. Thank you very much, Dr. Koop. Thank you, Madam Chairman.

Senator HAWKINS. Thank you, Senator, and thank you, Dr. Koop.

It is our responsibility to look at those consequences. We will let other Senators ask you questions. We thank you so much for your participation in this hearing and your timely printing; the ink is hardly dry on my copy of the report. We appreciate your expeditious response.

We will excuse you at this time.

Panel 2 will consist of Dr. Lee Ann Hoff from Massachusetts, Chair of the Workshop on the Evaluation and Treatment of Victims of Rape and Sexual Assault; Dr. Jean Goodwin, Chair of the Workshop on the Evaluation and Treatment of Victims of Child Abuse; and, Dr. Douglas Sargent from Michigan, Chair of the Workshop on Prevention of Child Abuse.

We thank you for appearing today. I would also like to welcome the students from Gallaudet College who are with us today. We are glad to have you visiting us. Dr. Hoff, we will have you proceed first with a summary of your statement, please, in the interest of time.

STATEMENTS OF DR. LEE ANN HOFF, BOSTON, MA; DR. HEAN GOODWIN, MILWAUKEE, WI; AND DR. DOUGLAS A. SARGENT, GROSSE POINTE FARMS, MI

Dr. HOFF. Thank you very much, Madame Chairman, for this opportunity to testify at this hearing. I come to the hearing with a great deal of enthusiasm from the workshop at Leesburg, and I guess I would like to start with a sort of broad historical sweep, if you will, on the topic that I worked with, which is the prevention of rape and the evaluation and treatment of rape victims.

There is an old saying that those who do not know history are doomed to repeat it. Now, interestingly, in respect to rape, we have the unfortunate fact that rape has been present in the history of the human race, but we also have seen through this historical account that predominantly the victims of rape have been women and the perpetrators of rape have been men, which points to another historical fact, and that is the social inequality of women. Now, this gets into a point about rape and myths and facts about rape, which is very critical to the kind of recommendations that our committee made.

And that is that rape is a crime. Rape is a criminal offense, and yet the majority of the general public, as well as service providers

and many people in the criminal justice system, do not treat rape as though it were a crime. As a consequence, the majority of rapes that actually occur do not get reported, and another misfortunate is that when they are reported and dealt with, the victim often is brutalized a second time through mishandling in both the criminal justice system and the health professions.

Now, my own sense of this problem is that in spite of how difficult it is and how shocking it is to face the kinds of facts we have is that I am still very enthusiastic because I believe that history does not have to repeat itself, that things do not have to be the way tney are. Since we have found that service providers very often share the same myths as the general public, we need to aim at educating those service providers as well as the rape victims or potential victims about what they can expect. So one of the major recommendations, and Dr. Koop has already referred to it, but we would reemphasize that in our subcommittee; is that, specific education programs be targeted to victims, assailants, and service providers.

And here I want to add that I do not think this workshop is going to end in a simple stack of reports that will land on someone's desk. For example, in my profession, which is nursing, we convened a short caucus at the Leesburg meeting and made a decision to get a brief one-page report out as a news article in all the professional nursing journals that will emphasize to nurses as front-line workers their critical importance in helping to evaluate and treat rape victims and to prevent rape.

Another of our recommendations was to pursue a media program because we feel that so much of rape is connected with pornography and the point that you made earlier about media portrayals.

A third recommendation we had is to make greater efforts to bring about equality between women and men because we have research that reveals that where the status of women is higher, the victims of higher or the rates of rape are lower. And so the importance of improving the status of women I do not think can possibly be underestimated because historically that is how rape has been associated and it is still true; it is incontrovertible that rape is associated with the low status of women.

The other recommendation I want to highlight is the issue of marital rape. We still have 22 States and territories in which rape is not considered a crime in the legal sense. This means basically that married women cannot claim, of course, being raped. And we urge that action be taken by those States to include marital rape as the crime that it is.

Again, historically, this can be traced to the fact or an understanding of women as men's property.

Another of our recommendations focused on looking to the rapist and deterrents and some of the kinds of education programs that have already been referred to by Dr. Koop; namely looking to alternative ways to resolve conflict rather than through power, domination, control, and violence.

Another major recommendation that we made is that every institution in which rape victims appear should provide an ombudsman or an expediter type of person that would assist the rape victim through the process of evaluation, treatment, and recovery since so much of what happens to a rape victim is double victimization as a

part of simply going through the system. And so we want to really emphasize that piece.

I want to close my testimony by emphasizing the fact that I opened with which is that even though the crime of rape has been with us since the beginning, I do not believe it need continue. I think it is a curse on our society, and I want to emphasize that, as Alice Walker said in one of her statements, justice is the only way to stop a curse. Rape victims need a sense that they have been compensated for the evils that have been done to them.

We have evidence from psychiatric and other kinds of counseling data that if victims do not have some sense that the crimes committed against them have been taken seriously, it is very difficult for these victims to have a sense of healing and emotional reconstitution over time.

And so I recommend that we do something in a very concerted way to see that not only does the rape victim get treated but that we do something in society as a whole that that victim can say that her suffering and her trauma have not been meaningless, that at least it may have done something to prevent this kind of thing for other people. Thank you for this opportunity. I am open to questions.

[The prepared statement of Dr. Hoff follows:]

Statement By
Lee Ann Hoff, RN, PhD
Associate Professor, Northeastern University College of Nursing
Consultant on Victim Assistance for the State of Massachusetts

Madame Chairman and Members of the Subcommittee:

Rape is a crime of violence with potentially life-shattering consequences for victims. The violence intrinsic to this crime is learned from the social approval of violence evident in the media, pornography, child-rearing practices, family violence, and other forms of violence in our society. And the fact that rape is primarily inflicted on women signals the basic social inequality of women.

Common myths about rape form a powerful barrier to prevention and impede treatment of rape victims and rapists. Therefore, we recommend that...

- Specific education programs be targeted to potential victims, assailants, and professional service providers.
- The media's portrayal of sexual aggression be evaluated as to its effects on public health.
- Greater efforts be made to bring about equality between men and women, since research has revealed that rape rates are low where the status of women is high.
- Actions be taken to remove the husband's exemption from prosecution in the 22 States and Territories in which wife rape is not a crime.
- Research should explore the recovery process from sexual ,assault, including the responses of family and significant others.
- Research should be continued on the behavior of rapists and the effectiveness of programs designed to deter them.

We further recommend that...

- Adequate support be given for programs serving rape victims.
- And that institutions should provide the services of an ombudsman to guide each rape victim through the process of evaluation and treatment.

The crime of rape is a curse on our society. And, to quote Alice Walker, "Only justice can stop a curse.

Thank you.

Senator GRASSLEY [presiding]. Dr. Hoff, we ought to go to Dr. Sargent, and then ask the entire panel questions. I do not know what Senator Hawkins' practice is, but that is my practice on my subcommittee. Since she is not here, I will call on Dr. Sargent.

Dr. SARGENT. Senator Grassley, Madam Chairman, and other members of the subcommittee, it is a privilege to appear before you. I come with a sense of urgency brought by the work group on prevention of child abuse and the work group on the diagnosis and treatment of victims.

As a physician specializing in psychiatry, I have a particular interest in the psychological effects of abuse upon children. At present 90 percent of our efforts to combat abuse are directed at repairing injuries, detecting those injured, and monitoring the victims against reinjury.

Yet the most important effects of abuse are the psychological residue of abuse, as these at present attract approximately 10 percent of our injuries.

Looking to the hospital emergency room and the people who work there for ideas about prevention of abuse is about as useful as looking to the auto body shop for ideas about preventing automobile wrecks. Our work group decided to look beyond the body shop in the emergency room and focus on what might be done to prevent abuse.

When we did, we had a range of recommendations, and the primary was an increase in public awareness that abuse includes also abusive neglect, poverty, and other injustices against children.

We recommended that a nationwide campaign be conducted immediately to reduce public acceptance of violence and to protect children from all forms of violence including corporal punishment in the schools.

The role of the media, obviously and transparently, is vital in such a campaign, and we certainly would welcome their help.

We recommended also educational and support programs to be provided for families, including home visitor services that promote the health and welfare of vulnerable children as a public health priority. We recommended culturally appropriate education and support programs in proper parenting to be provided to parents and families at greatest risk for abuse.

Our companion workshop on treatment, surprisingly enough, recommended expansion of child and family health services to free child protective services to concentrate on problems of serious abuse and neglect of victims.

Our panel also made the recommendation that planning for parenthood be considered a primary step, a first step in the prevention of abuse and that preventing undesired pregnancy is a first step in that planning process.

We believe that the Nation is impressed by the need for attention to the problem of violence against children, but we also recognize the limitations of the criminal justice system to do anything constructive to help the victims. We recommend, along with other groups, that ways be found such as those presently in place in California, to insulate victims who are called as witnesses to their own abuse from the kind of abusive cross examination and the inherent stresses of the legal process, and we believe that such ways can be

found. It is our impression that abuse is violence, and that abuse leads to further violence.

One member of the workshop, Dorothy Lewis, a psychiatrist from Bellevue, has convincingly pointed out that those delinquents who later become murderers can be distinguished from a group of delinquents who did not by the presence of five factors, one of which was that they experienced severe abuse in childhood.

Senator GRASSLEY. Dr. Sargent, I am sorry. I will have to interrupt and ask you to stop because Senator Dodd and I have to go vote. We thought Senator Hawkins would be back here, so we did not have to break it up. So will you just sit at ease for a minute?

Dr. SARGENT. We will have a halt in place.

Senator GRASSLEY. I am sure it will be 5 minutes or less. Thank you.

Dr. SARGENT. Thank you.

[Brief recess.]

Senator HAWKINS. Dr. Sargent, I understand you are in the middle of your testimony. You may continue.

Dr. SARGENT. Madam Chairman and members of the subcommittee, to continue: I was just about to refer to the work of Dorothy Lewis, a woman psychiatrist at Bellevue Hospital who demonstrated convincingly that she could distinguish between delinquents who became violent and murderous and those who did not by the presence of several factors that could be detected in their life stories before they became delinquent, and among those factors was the presence of severe abuse directed at them in childhood.

Another factor of very great importance was that in the earliest years, ages 1, 2, 3, up until about 6, the rate of hospital admissions and hospital emergency room visits for those delinquents who later became murderous was double the rate for other delinquents who were not violent. And again at the beginning of adolescence, and continuing through adolescence, the emergency room and hospital admission rate for those delinquents who later killed someone was double that of their less violent peers.

Strangely enough, however, that when admitted to houses of detention for juvenile delinquents, the pediatricians on duty there did not pick up the history of prior medical difficulties nor brain injury, which many of them experienced, which suggests that these are cases of medical neglect among other things.

I would like, Madam Chairman, to leave a copy of Dr. Lewis' interesting paper with you. I would like to mention the fact that I was chairman of the American Medical Association's Advisory Panel on Child Abuse, and last spring, the American Medical Association published, to increase the information available to physicians, the American Medical Association Diagnostic Guidelines Concerning Child Abuse and Neglect. We hope to follow this later with guidelines specifically aimed at preventing child sexual abuse.

Madam Chairman, this is the end of my formal presentation. I would welcome questions.

Senator HAWKINS. Thank you very much. Dr. Goodwin.

Dr. GOODWIN. Madam Chairman, over the past 5 to 10 years, reported cases of sexual abuse of children have increases geometrically, an increase which has underlined our need for more effective response systems.

In that light, my work group recommended that there be timely focused, multidisciplinary assessment of suspected cases in a systematic way so as to minimize the amount of reinterviewing, reexamining, and retraumatizing of child victims; also, that there be continuing education and the immediate availability of consultation for front-line professionals in both the legal and the health professions who must work with these children and their families.

Regional and national resource and information systems can assist in this process. These centers could provide professionals and affected families with a full range of up-to-date human and informational resources.

More research and more sources for research funding are needed in this area. Treatment outcome studies in the area of child sexual abuse should focus on those sexually abused children who experience severe and multiple abuse, severe health and mental health symptoms, and drastic loss of function.

We also need to understand how to help offenders, especially those who are themselves young, abused adolescents so that they can refrain from sexually exploiting new child victims. We respectfully submit these highlights from our more extensive recommendations in the area of assessment, treatment, and prevention. Thank you.

Senator HAWKINS. Thank you. I know both you ladies have planes to catch shortly, so I will ask you a brief number of questions and you can catch your airplane.

Dr. Hoff, Susan Brownmiller in her book entitled "Against Our Will: Men, Women, and Rape," outlines some common beliefs perpetuated by society, such as all women want to be raped, women falsely accuse innocent men of rape, women provoke rape by their very appearance, women secretly enjoy being raped, and nice girls do not get raped.

What do you believe is the cause of such misconceptions, and what do you think could be done to eradicate this type of thinking?

Dr. HOFF. First of all, Madam Chairman, I believe that beliefs have a very powerful function in society, and for me, anyway, beliefs contribute to maintaining things the way they are. As long as the majority of people can believe that women want to be raped, that they enjoy it, and the other kinds of myths, pure myths about this topic, then this provides an effective barrier to ever doing anything about stopping rape because mythology does constitute, really, a charter for behavior, and in our society myths about rape constitute a charter, in a sense, for not doing anything to stop the underlying causes of rape. As I noted in my earlier testimony, my earlier statement, the underlying cause of rape is, from my point of view and the majority of the evidence of all people who have written and studied and worked in this area, is that it is an expression of power relations between men and women with men holding most of the power and women holding very little of it. And so rape is very, very much symbolic of that. And so I believe fundamentally that if we want to do anything about this underlying cause, we need to radically change the power structures as they currently exist to a more equal share in all aspects of power for women and men.

This includes, by the way, I think very importantly the issue of child rearing, which I think cuts across other aspects of our work at the Leesburg Conference. And that is I think that through the kind of socialization that happens in early childhood little boys typically learn to solve conflict through domination, control, and violence, and little girls typically are taught and learn to be submissive, passive, et cetera.

This kind of lays the groundwork, if you will, for later kinds of domination and control tactics between the sexes. I, furthermore, believe that a radical change in the issue of who primarily rears the children needs to be changed. Right now most child rearing is done primarily by women, and I believe that fathers should have an equal role in rearing their children in terms of parenting and that if we had more tenderness on the part of fathers—this was brought out by one of the psychiatrists in my work group, that unfortunately men get the impression that they need to go through life without a very easy way to express tenderness—we would have less conflict, domination, and resolution of problems and power struggles through violence.

And so I think that as one family therapist said one time, until men take an equal share in the unpaid work of society, which is child rearing and housework, women will never be equal in other places. I believe we have made some progress in that direction, and we have some very good beginnings, but I think we need much more in that kind of direction.

Senator HAWKINS. I believe that the public has a general perception that physical violence is a necessary component of rape. But most teachers instructing potential victims how not to become a victim say if you happen to be attacked do not resist, because you may put your life in danger.

Does this result in the misperception that a woman who cannot show physical evidence of fighting back, who cannot show that she physically resisted rape, really cannot then prove rape?

Dr. HOFF. I think that that is one of the issues that goes with the mythology that you mentioned earlier, which is that women somehow invite it, and it goes with the myth and the lack of appreciation of the severe threat to life that often goes with the rape experience that can result in no physical evidence from the point of view of injury, but that does not account for the fact that a gun may have been held to her head and that she had no other alternative than to not resist; it was either rape or her life.

Senator HAWKINS. What type of long-term medical and psychological problems is the rape victim likely to develop?

Dr. HOFF. They potentially are multiple. A woman can have problems that will manifest themselves in later sexual dysfunction. She may be depressed. She may continue to blame herself in some way for what happened, and my own view there is kind of self-blaming that many victims do. And here again you see a relationship between rape and other kinds of victims, especially battered women, that, yes, these women blame themselves, but they do that because society has first blamed them.

And so my own analysis is that society blaming and self-blaming often moves to depression and suicide attempts and sometimes

completed suicide. And so potentially a woman can have all kinds of sexual difficulties, and emotional difficulties later on.

I want to add, though, that this is not necessarily inevitable. I mean, a woman does not necessarily remain traumatized for the rest of her life. A major piece, though, that I think would influence that kind of negative pathological outcome would be the kind of treatment she receives at the time of the rape. Did somebody blame her? Was she assisted with an advocate and crisis workers and people to help her through the experience so that she does not end up blaming herself, and so forth.

There is a lot of evidence in the crisis literature and the psychiatric literature pointing out that if there is early and appropriate intervention at the time of the crisis, at the time of the trauma, many, many later implications can be avoided.

This was a major piece of the Leesburg Conference, I believe, the importance of early intervention strategies to prevent later kinds of pathologies and outcomes.

Senator HAWKINS. I have read a lot lately about "date rape." Do you have any statistics on this?

Dr. HOFF. Not precise ones, except that in general we have underreporting of rape, and of course with date rape, you see, the myths are even more prevalent because of the fact that if the woman was out with the person and even if she was interested in some kind of sexual contact but later it turned into a violent contact, that somehow that lays the foundation for greater blaming of this victim.

But, yes, there are a great number at least of suspected date rapes or also acquaintance rapes that are more difficult to report because of the victim fearing that the traditional misunderstanding and blaming are going to be more dramatically exposed than in, let us say, the kind of "blitz" rape or the rape by a stranger where there is dramatic physical damage, and the like.

Senator HAWKINS. Is there less a need for treatment?

Dr. HOFF. For date rape?

Senator HAWKINS. Yes.

Dr. HOFF. Not necessarily. In fact, there is a lot of evidence here about marital rape, that in some respects this type of interaction is even more traumatic for the victim because she was not expecting it, because she was anticipating a normal relationship that then turned into a violent kind of act as compared with stranger rape. So marital rape or date rape or rape in which the context was an expectation of respect, and so forth, but where you have the tables completely turned, the potential for emotional trauma is perhaps even greater.

Senator HAWKINS. Do many victims of rape turn to alcohol and drugs?

Dr. HOFF. I do not believe we have exact evidence on that, but I would tie that to the point I made earlier, which is that when people do not get the kind of help they need at the point of crisis and upset at an event like this, the potential for resolving the conflict, the trauma, and the emotional pain later through alcohol and other drug use is, of course, greater.

It certainly is not a trend that is currently available in the literature.

Senator HAWKINS. Thank you. I have some other questions that I will send to you and hope you can catch your plane.

Dr. Goodwin, the last hearing I chaired in the subcommittee on October 1 was on the exploitation of runaways. In your opinion is the runaway or the throwaway, the homeless child population at risk for sexual abuse?

Dr. GOODWIN. They are not only at risk for sexual abuse once they get on the streets, but many of them are running away from sexual abuse in the home or community or neighborhood. One of the specific recommendations of our prevention group was that that group of homeless teenagers be targeted specifically for prevention and intervention.

Senator HAWKINS. Several years ago when this Senator was working on missing children and trying to get the Justice Department to include runaways in missing children reports, it seemed to me to be their mindset that a runaway was a bad kid. Have you had to encounter that, and has that definition changed in the last few years?

Dr. GOODWIN. Well, I think that blaming the victim is such a pervasive maneuver that we engage in that it is going to take initiatives like that of Dr. Koop to try to really change the attitudes in this area. Certainly the children that Dr. Sargent spoke about, the delinquents who become violent and ultimately become murderers are seen as bad kids, and I think that view of them is part of what keeps pediatricians from noticing that not only are they bad kids, but they are kids who were severely neglected in infancy, severely battered in childhood and adolescence, and that there is another problem at work here, which is basically a public health issue.

Senator HAWKINS. The runaway and homeless youth centers report that the children they are serving are increasingly more troubled; they are often forced to deny services to a runaway child because the center is not equipped to deal with the child's alcohol problems, the child's drug dependency, or their suicidal tendencies.

Do you think that it would be helpful to have a mental health or a substance abuse component added to youth shelters?

Dr. GOODWIN. Well, many of the shelters have called me asking me to help them set up victims' groups for some of the kids who end up in such shelters who reveal a prior history of molestation in childhood. I think that is just the beginning of services that we probably quite desperately need, which should be systematized and organized and informed in much the way that we recommended that assessment services be organized.

Senator HAWKINS. The private sector, both nonprofit organizations and large corporations, have been very helpful in disseminating information regarding missing children and in issuing child safety messages. For example, child safety tips are now appearing on the backs of breakfast cereal boxes. Greyhound and Trailways bus lines are offering runaways a free ride home. Spiderman comic books and comic strips talk about child sexual abuse.

Do you think that we could tap into the private sector also to help combat forms of violence?

Dr. GOODWIN. Definitely. I was really cheered up when Senator Metzenbaum started talking about the AFL-CIO and the Jay Cees

and on and on. If each of those groups could offer a series of small grants for demonstration projects and for small research projects, we would be way ahead of the game in terms of being able to organize the services that we need.

Senator HAWKINS. The National Center on Child Abuse and Neglect and related child welfare agencies within individual States tend to restrict their official definition of child sexual abuse to activity at the hands of caretakers. This restriction is designed to separate child welfare functions from the criminal justice function, and so it excludes molestation by strangers.

Do you approve of that separation?

Dr. GOODWIN. Well, it is not a separation that exists now in all States, and in fact the two States where I have worked most recently, New Mexico and Wisconsin, do include services to children molested by strangers in their child protection services.

I think that there is a problem in this area which maybe defining the issue as a public health issue will help bail us out of in that we keep elaborating definitions which are almost designed for cases to fall through the cracks, and, you know, I think many of the criminal justice definitions are so restrictive and really necessarily so that the majority of cases really do not qualify by criminal justice definitions for any kind of intervention.

However, if you think of the issue as a public health issue, if you are trying to prevent or reduce symptoms in both the victim's family and the alleged perpetrator, I do not think you have to be quite so nitpicking about how you define things.

The issue then becomes to have a coordinated, multidisciplinary system of response for all cases, even those where the level of suspicion is very low.

Senator HAWKINS. I have one last question and then I will have Senator Dodd ask you questions so that you can catch your 1 o'clock plane.

In the hearing we had here on the Children's Justice Act, I recall talking with the parents afterwards of the children who had been abused, and they were in a quandary because of the legal-medical advice they were being given. The medical advice was that the children who had been abused should have counseling.

The legal advice was if you do that, they will throw the case out of court because the child has been coached in legal terms. Is this clash of philosophies between medical and legal response to child abuse destroying the punishment or the treatment or both?

Dr. GOODWIN. Well, I think that there are problems that need to be worked out. I do not think they are beyond working out if we talk to each other. In point of fact, despite all of the attention that is focused on the criminal justice prosecution aspect of these cases, only a tiny percentage of the total number of cases are ever successfully prosecuted.

So I feel that focusing all of our energy on that kind of intervention may be missing the boat on other kinds of intervention which might be less expensive, less potentially retraumatizing of the child.

Those interventions may be where we need to put our effort.

Senator HAWKINS. Senator Dodd.

Senator DODD. Thank you very much. I will be relatively brief. I think all three of you were here when I asked Dr. Koop about the failure to report and how we might deal with that problem in terms of spousal abuse. We have statutes, as he appropriately pointed out, dealing with child abuse. Let me just ask all three of you—and I will start with you, Dr. Goodwin, if I could, on how is that working. What is happening in terms of existing statutes with regard to position reporting requirements on child abuse, just a general picture of what we are getting from that. I am told that it is not anywhere near as good as it could be or as it should be.

I do not want to prejudice your response. What is the situation?

Dr. GOODWIN. Well, I wrote a paper on that, but I cannot remember exactly what my numbers were. I was looking in particular at whether physicians were reporting child sexual abuse when they saw it, and there have been a number of studies in that area in the past 10 years. And the message of my study, which was one of the most recent, is that we have gotten better. We have gotten quite significantly better, but we are still reporting only two-thirds of the cases that we should report.

Senator DODD. There was a Dr. Dupres, a psychiatrist in Los Angeles, who has done a study of childhood gonorrhea which held professionals treated the child for venereal disease but never reported sexual abuse. Is that the exception or does that happen elsewhere?

Dr. GOODWIN. I am afraid that unfortunately it does happen elsewhere, and it is one of those things, those educational things that we just have to say over and over and over and over again. The hundredth time you say it, there is still somebody in the audience who raises their hand and says but could not this 2-year-old have gotten it from bathing with the mother, and so forth.

So it is just one of those things that is terribly hard to get through to people. I think people are not terribly rational around violence and aggression. When you add sexuality to that, they get terribly irrational.

Senator DODD. Just for the purpose of the record, what is the likelihood of a child contracting gonorrhea from taking a bath with its mother?

Dr. GOODWIN. Zero. Or as close to zero as we ever get in medicine.

Senator DODD. So in that kind of a case there should be no question in any physician's mind about what has occurred to that child.

Dr. Newberger as well at Children's Hospital wrote one of the two papers; he has been working on this problem of physician nonreporting, which I should mention here as well. Dr. Hoff, the *Gary Dodson* case, a case of rape, obviously the tragic circumstances of that case; what has that done in terms of reporting? Has there been any noticeable effect or dropoff in reporting of rape? That case received such incredible notoriety.

Dr. HOFF. To my knowledge, I do not think that we would have the statistics in yet because that case was so recent that the official reporting records as to what effect that case had on the total reporting of rapes, I do not believe is in yet, as far as I know, because there is usually quite a lag in terms of official statistics here.

The kind of speculation about that case is that it certainly may deter some victims of rape from reporting. I guess the hope is,

though, that people would not take that one case as a norm rather than as an aberration and a very unusual kind of instance.

It is a most unfortunate thing because it feeds into the dominant myth that women lie and that they accuse rape for all kinds of reasons, and it is, as I said, just one of those very unfortunate kinds of things.

Senator DODD. Is that being followed, though? Are we going to be able to get some information about that? I mean, I think that would be an important statistic, and I do not think you can just use the date and then what happens afterward. I would like to know if there are some interviews being conducted, and so forth.

Dr. HOFF. I personally do not know if there are. Maybe there are other members of the panel or group that do, but I do not know of any official research being done on that at the moment.

[Information supplied for the record follows:]

Knowledge and Management Strategies in Incest Cases: A Survey of Physicians, Psychologists and Family Counselors

Reina Attias, B.A.
Executive Director
Las Familias, Inc.
P.O. Box 4620
Albuquerque, NM 87196

Jean Goodwin, M.D., M.P.H.
Associate Professor
Department of Psychiatry
University of New Mexico
School of Medicine
Albuquerque, NM 87131

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Send reprint requests to Reina Attias.

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Key Words: incest, child abuse, child protection, intrafamilial child sexual abuse, professional attitudes.

Abstract - A questionnaire was mailed to all 255 psychologists, psychiatrists, pediatricians, and family counselors listed in the 1983 telephone directory. Of the 108 private practitioners who responded, over one-half had treated a child or adult incest victim in the past year; 86 percent requested more training in this area. Practitioners had a high level of general knowledge about intrafamilial child sexual abuse. Nevertheless, one third stated they would not refer to protective services a child who had first made, but then retracted, an incest allegation. While most pediatricians would recommend physical examination of a child who had retracted, only half of other professionals would do so. Women practitioners were more realistic about the high frequency of actual father-daughter incest and were more likely to report the hypothetical case of the retracted allegation.

INTRODUCTION

This article reports a survey of professionals in private practice, assessing their knowledge about incest and the management strategies they use in incest cases. The authors sent a mail questionnaire to private practitioners in a large city in the Southwest United States. The questions probed the following areas: 1) strategies chosen for evaluating a family in which an incest accusation has been made 2) information about the epidemiology of incest 3) amount and kind of experience with incest cases 4) sources of information about incest and felt needs for further training. We also asked clinicians to describe the most common problems they encounter in these cases.

Previous studies (1-8) have focused on professional reluctance to report either physical or sexual abuse of children. Anderson (1) found that of 144 physicians surveyed in Nova Scotia, 47 percent were unaware of the specific law relating to reporting child abuse. Silver, et al. (2) found that over 20 percent of physicians would not report child abuse even if they suspected it. In a survey of over 1,000 physicians, Chang and co-workers (3) reported that only about one-third of child abuse cases recognized by physicians in this sample had been followed up by a child protective agency. James and co-workers (4) surveyed 96 pediatricians and family physicians. Over one-half of the physicians had seen at least one case of intrafamilial sexual abuse in the previous year and 93 percent

of them felt that the patients in question had been seriously traumatized by the incidents. However, only 32 percent of the physicians had urged at least one person in the family to report the incident and only 42 percent stated that they, themselves, would report confirmed sexual abuse. Anglin (5) found that pediatricians who had been trained during residency to manage sexual abuse cases were more likely to recommend appropriate interventions. Swobada and co-workers (6) and Finkelhor and co-workers (7) found that other professionals, in addition to physicians, have difficulty complying with the legal mandate to report physical or sexual child abuse. Boston professionals had reported to protective services only about two-thirds of their incest cases. Social workers, too, express a need for more training with over 70 percent rating as deficient their preparation for managing incest cases (8,9).

As public awareness increases, more children and adults seek treatment for ongoing or prior sexual abuse. It becomes important to know what skills and information practitioners are bringing to this increased caseload. This is especially critical because it has been shown that the initial handling of a case may influence the entire long-term course (10). More precise information about levels of knowledge and expertise among professionals will allow for better design of continuing education about incest.

Methods

Subjects: The study sample included all practitioners listed in four categories in the yellow pages in the 1983 telephone directory of a large city in the Southwest United States. The 255 practitioners included: psychiatrists (n=44), psychologists (n=98), pediatricians (n=36) and marriage, child and family counselors (n=77) All subjects received one mailing of the study questionnaire with a covering letter. No follow-up calls or interviews were conducted.

Questionnaire: The questionnaire included 3 true/false questions yielding 3 responses, and 7 multiple choice questions yielding 17 possible responses (respondents were asked to designate all correct answers). There were 6 open-ended questions.

The following case example assessed clinician's management strategies:

> An eleven-year-old girl describes graphically to her school counselor fellatio and cunnilingus with her natural father, ongoing for more than 2 years. There is one male sibling at home, age 8. She says she had already told mother who did nothing. The child is doing well, educationally and behaviorally, at school and complains of no sleep disturbances, depression, anxieties or phobias. At this point the school counselor refers the case to you for evaluation.

Three true-false questions asked whether such a child should be reported to child protective services, to the police, or be screened for venereal disease. These three responses, based on local law and standard practices, were scored as "correct" or "incorrect." Practitioners were then asked to designate any aspects of the case they considered "atypical." The questionnaire then asked practitioners what they would do if the child in this hypothetical case retracted her allegations.

The next series of questions asked clinicians to estimate the frequency of fantasy-based incest allegations, of positive findings on the physical examination, and of sibling involvement. Additional questions covered the frequency of father-daughter incest among women in the general population and the percentage of men who are identified as the offender in reported incest cases.

These multiple choice questions which covered the epidemiology of father-daughter incest were more difficult to design and to score. There is as yet no solidly agreed upon scientific data base in this area. However, there are recently published large clinical surveys of incest victims which provide initial estimates. The questionnaire was designed such that responses had to be quite far from percentages reported in this literature before they were scored as overestimates or underestimates. For example, practitioners scored as underestimating the prevalence of prior father-daughter incest among adult women had to choose prevalences of 1 per 500, or 1 per 2000, rather than 5 per 100, or 1 per 200. Similarly,

those practitioners who were scored as underestimating the likelihood of finding positive signs of abuse or neglect on the pediatric examination, chose the answer "under 5 percent."

Data Analysis: Percentages of "correct" and "incorrect" responses were tabulated. The Yates correction of the Chi Square Test was used to compare percentages found in sub-groups.

Results

Characteristics of Respondents: A total of 108 (43%) of the 255 questionnaires sent to professionals were returned. This response rate of about 50 percent is similar to those in other published studies in this area (1,3,4). As shown in Table I, there were no significant differences in response rates for the four groups, although marriage and family counselors showed a slightly lower rate of response. Since the number of psychologists listed in the telephone directory was greater than the other disciplines, the data overrepresents psychologists and underrepresents medical professionals. More than half (62%) of the respondents were between 35 and 50 years of age. Psychiatrists and pediatricians were predominantly male (81%), while psychologists were 63 percent male, and counselors were only 25 percent male.

General Findings: Ninety-eight percent of the respondents were aware that intrafamilial child sexual abuse, as described in the case example, must be reported to child protective services. However, only 79 percent of the respondents knew that a child who alleges fellatio should

be screened for venereal disease. Although 15 of 16 pediatricians who responded recommended such screening, only 76 percent of professionals in the other 3 disciplines were aware of the need for such screening in this community where there is a high baseline prevalence of gonorrhea. There was general agreement among all professionals that in the case described in the questionnnaire, the victim's age (11 years old), the non-responsiveness of the mother and the long duration of contact were typical (10,11,12). Only 12 percent considered it atypical that a natural father was accused. (Although girls with stepfathers are at greater statistical risk for intrafamilial sexual abuse, in a clinical sample more than half the sexually abusing fathers will be natural fathers (11)).

After a retraction by the child, all professionals recommended a psychological evaluation. However, only half recommended physical examination of a child who had retracted an allegation involving oral-genital contact with a parent. Seventy-five percent of pediatricians recommended physical examination even after retraction.

After retraction by the child, more than half the psychiatrists and less than a third of the other three disciplines would choose not to refer the family to Child Protective Services.

Although available literature (3,13) suggests that very few (5% or fewer) children who disclose incest are recounting a fantasy, some practitioners in all disciplines overestimated this percentage by five-fold

or more. Those who overestimated most frequently were psychiatrists with 40 percent estimating that 25 percent or more of children's accusations are fantasies.

Only a little over half of the respondents (57.7%) were aware of the high frequency (15-25%) of physical signs of abuse and neglect in a child who makes an incest allegation (14) and 61 percent were knowledgeable about the high frequency (30 - 40%) of sexual involvement of siblings with the alleged perpetrator (15,16).

On general information about incest and early childhood sexual abuse and its sequelae, only 62.2 percent of all professionals were aware of the high prevalence of father-daughter incest (0.5% to 5% of women) and only 57 percent identified males as the perpetrators in the majority (96%; any response over 80% was accepted) of reported sexual offenses against children (16,17).

In an open-ended question aimed at eliciting professionals' opinions about the kind of family in which incest occurs, more than half viewed the family as dysfunctional, socially isolated with marital problems, while 29 percent viewed such families as "normal" intact typical families. Other descriptions included alcohol or drug abuse (7%), socio-economically deprived (11%), inadequate mother (11%), and inadequate father (12%).

Gender Differences

Sixty-four (59%) of the respondents were male. Of the 20 items scored for accuracy of response, 5 items revealed large differences in

gender response. As shown in Table II, professional women tended to respond in ways which indicated that they viewed incest as a more serious and prevalent problem. Only a small percentage of women (8%) considered it atypical that a natural father was accused in the presented case illustration, while double that percentage (16%) of the men considered it atypical (not a statistically significant difference). After an incest allegation has been retracted by the child, more women (79%) than men (62%) would recommend referral to Child Protective Services (X^2=3.0; p=.08) and more women (56%) than men (45%) would recommend a physical examination (not statistically significant). More men (25%) than women (9%) overestimated the percentage of children who report fantasies, rather than real occurrences of incest (X^2=4.0; $p < .05$), and more men (46%) than women (22%) underestimate the frequency of father- daughter incest (X^2=5.9; $p < .02$).

There were no questions for which male respondents provided accurate answers with significantly greater frequency than did female respondents.

There were no significant differences in responses to any question when practitioners in different disciplines were compared or when practitioners with recent experience managing incest cases were compared to those without recent experience.

Experience and Need for Further Training

Fifty-nine percent of all professionals had at least one contact with an adult incest victim in the previous 12 months, and 48 percent had had some experience with child victims in that period.

The most common clinical problems cited in an open-ended question were problems managing the sequelae of incest in victims. The most frequently cited problems were (in rank order): depression, poor self-image, suicidal impulses, impaired intimate relationships, anger, guilt, borderline personality disorder, and sexual dysfunction. Other clinical problems mentioned were 1) the perpetrator's and family's denial and 2) dealing with social service agencies and the legal system. Professional journals and texts and professional meetings were cited as the most important sources of information.

Almost all professionals (96%) responded affirmatively (frequently emphatically) to the question: "Do you see a need for more information in this area?" and 86 percent responded affirmatively to "Is there any type of training that would be most useful to you as a professional working with incest cases?" The most frequently mentioned information desired was 1) information about identification and diagnosis of incest and treatment options 2) public information about prevention through school programs, media and general public awareness through education and 3) research results.

The type of training requested most frequently involved workshops provided by trained specialists covering treatment strategies, behavioral sequelae, appropriate interventions, and improvement of diagnostic skills through case presentations, supervision and video presentations of actual sessions with victims and their families.

DISCUSSION

Overall, the survey indicated that psychologists, counselors, psychiatrists and pediatricians in the community have a great deal of practical experience, knowledge and management skill in treating intra-familial sexual abuse, with half the practitioners seeing at least one case in any given year

Very few private practitioners (less than 20%) profess the stereotypes of a generation ago: that natural fathers are never involved; that parental denials are to be taken literally; that children's allegations are fantasies.

Ninety-eight percent of practitioners knew that reporting to Child Protective Services was mandatory, but in the confusing situation of a retraction, about one third of the respondents still would not report, and half would not be concerned about the need for physical examination of the child. However, the responses to this questionnaire, when compared to earlier studies, indicate an increase in the willingness of professionals to report. In 1973, Anderson and co-workers reported that only 47 percent of physicians were aware of any reporting law; and James, and co-workers found in 1978 that only 58 percent of physicians would report confirmed sexual abuse (1,4). Increased attention to this problem in the past five years seems to have had an impact.

This need to translate new information into routines for management seems the basis for the very sensible suggestion by respondents that the type of training needed now would be clinically focused workshops; 96 percent of respondents said they wanted more training.

As a discipline, pediatricians seem to have the most to teach the other disciplines about the necessity for physical examination as part of a comprehensive approach to the child and about the hazards of venereal disease in this particular community. Non-pediatricians were less likely to recommend physical examination and also tended to underestimate the frequency of positive physical findings. This frequency, with the addition of new magnification techniques for detecting microtrauma, will become even higher than the 25 percent figure now reported in the literature. Cross-disciplinary training and collaboration are obviously needed.

Practitioners may have some difficulty looking beyond the incest allegation in order to make a problem list for the entire family. In an open-ended question, 29 percent of respondents stated these were "normal" families with no other problems. In part, respondents were reflecting the accurate insight that many incest families fail to fit the stereotype of the "multi-problem" family. However, about 40 percent underestimated the likelihood of finding other abuse victims among siblings.

It was surprising to find that gender, rather than discipline or personal clinical experience, was an important predictor of response on key items. More men than women overestimated the percentage of children who make false accusations of sexual abuse. More men than women underestimated the prevalence of father-daughter incest in the general population. More men than women would choose not to report to Child Protective Services a child who had retracted. What are the sources of these gender differences?

Men may have less access than women to recent research findings or be more skeptical of these findings. Future studies should explore this in more detail.

The impact of such gender differences on case management decisions may be magnified because males are overrepresented (80%) among the medical professionals who are most influential in the case conference situation which produces so many management decisions in child abuse cases (18).

Several theorists (16,19,20) have discussed the minimization of the problems of incest as a self-protective maneuver by males; these data provide some support for that position and suggest the need for role-playing and discussion of gender-related feelings as part of training in handling intrafamilial sexual abuse.

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Table 1. Numbers of Respondents Among the Four Professional Groups Surveyed

TOTAL		RESPONDENTS
36	Pediatricians	16
44	Psychiatrists	18
98	Psychologists	44
77	Counselors	25
	Unidentified on form	5
255	TOTAL	108

Table II. Assumptions Made More Often by Male Than Female Professionals

	Men	Women
Atypical for a natural father to be accused	16%	8%
Child Protective Services need not be informed if the child retracts	38%	21%
More than 25% of children who report incest are recounting fantasies*	25%	9%
Fewer than 0.5% of adult women have experienced incest*	46%	22%

*Difference is significant with $p < .05$.

Dr. GOODWIN. Excuse me. If I may interrupt here, I really need to leave. May I be excused?

Senator HAWKINS. Certainly.

Senator DODD. I have one more question, but I will send it to you.

Let me ask Dr. Sargent very briefly: In Sweden recently they came out with an ordinance to prohibit spanking. I do not know whether that is parental spanking or spanking in the school systems. I am not sure what it is, everybody, everybody who spanks anybody.

You recommend a campaign to reduce public acceptance of all forms of violence including corporal punishment in your report. What is your assessment of the Swedish example? Does that go further than you would? Is that encroaching in an area—I mean, there are those who argue that every now and then under the appropriate circumstances a spanking may not be the worst thing in the world for a child, certainly not something that ought to be done with great frequency or whim, but that every now and then to make a point as long as it is not done violently at all. I do not know if you can nonviolently spank someone.

I used to think they were pretty violent when I got them on occasion growing up. What are your views of that?

Dr. SARGENT. Well, every spanking I ever got was violent, and those that I avoided I also thought were going to be. That is why I avoided them. Swedes can do things that we apparently cannot. For example, they appear to be able to reduce infant death rate far below what we can achieve so that without speaking except with respect about the Swedish situation, let me say that our panel on the prevention of abuse recommended strongly a campaign against corporal punishment aimed primarily at those places where it is publicly sanctioned, but also with the hope that those parents who are able to profit from the good example would emulate it.

I find that people shake out on this point depending on how recently they have been provoked to spank. One of the very common reasons given by abusive parents for the physical abuse inflicted on their children is that I was punished as a child and it did me a lot of good is the inference. And, therefore, no one should interfere with my right to punish my child.

I find in general those who take that view have gone far beyond any rational definition of punishment as a disciplinary enforcement and are into the area of sadistic revenge. I think we would feel very successful if we could make universal the prohibition of corporal punishment in some schools and other agencies where children are under the care of others.

Senator DODD. Thank you very much, Doctor. Thank you, Madame Chairman.

Senator HAWKINS. Dr. Sargent, mandatory reporting laws for suspected cases of child abuse were enacted on the premise that abuse is easy to determine, and that there are certain physiological and pathological signs. Is the task of diagnosis, in your opinion, becoming confused with the task of investigating?

Dr. SARGENT. Yes, of course it is, because the reporting laws suggest that it must be. However, as you pointed out, most of the reporting laws in the States require only that the suspicion of abuse

be reported and the investigative phase is left to those whose job it is under the law to investigate.

However, since when physicians report, they are also immediately turned to as the source of official evidence for abuse. Their burden is somewhat greater than that of the average reporter.

I think that the mandatory reporting laws are good. I think that most physicians inadvertently or intentionally exercise some discretion in reporting. That is when they set their suspicions to the level of whether they report or not, the question as to whether physicians report enough or accurately enough is an open one.

I do know that in hospitals very often the physician sees an injury and indicates that a report should be made, which report is either submitted by the social worker or the nurse, and these are credited, if you will, to the nurse and social worker and are included among statistics of nonreporting by physicians which is fudging the facts. I think, though, that the contamination of the medical treatment situation by the needs of the criminal justice system is unfortuante. This is one of the reasons why we so welcome the new emphasis on public health and epidemiology as bringing a different force into play, one which we would certainly approve.

Senator HAWKINS. You stated some of the main factors that you feel lead to family members abusing children. Are there different factors that affect abuse by nonfamily members in contrast to family members?

Dr. SARGENT. Well, I think that is true. Actually, the most dangerous place for children is the home, and the most dangerous people are those who are their blood relatives and live-in acquaintances. It is the abrasions that occur often between ignorant or overburdened or stressed parents and children who may have a particular need for care that exceeds the care giver's capacities that is at the root of abuse.

We identified certain children who are especially vulnerable to abuse, who are high risk for abuse, who ought to make a claim for priority in attention. We included in our list runaways and children with physical and mental handicaps. Also we included the children of parents at high risk for abusing, and those would include solitary parents who are mentally ill or mentally retarded, parents who are homeless, and there are a growing number of those, parents which one partner is in prison, parents who have themselves been abused in childhood as the parents of potential abusers. We think that an emphasis on these high risk groups would do much to prevent abuse.

Senator HAWKINS. Would parent education on child development have any influence on the problem?

Dr. SARGENT. It is our impression that this would clearly have a beneficial influence and especially if you select the prospective parents, about to be parents, and parents of infants, and if the education includes hands-on and demonstration lessons in proper child care, proper parenting. These we believe would be invaluable.

Studies have shown that those children who were picked up in the Head Start Program and given special care showed reduction in problem behavior. The parents who continued to have access to support during the early childhood years continued to experience lower rates of problem behavior in their children when they

reached school years than did the parents of children who dropped out after the first Head Start years were passed.

We believe that continuing parent support, including the old home health visitor program that public health nurses used to do, would be an important step in that direction of educating parents.

Senator HAWKINS. Thank you very much. We appreciate your interest in this and your willingness to come today right after such a long conference. We will excuse you at this time.

Our next panel will include Dr. Ann Flitcraft, New Haven, CT, Chair of the Workshop on Prevention of Spouse Abuse; Dr. Kosberg, Chair of the Work Group on Elderly Abuse; and, Dr. Waller from Michigan, Chair of the Work Group on the Prevention of Assault and Homicide. I am pleased to welcome Dr. Kosberg from Tampa, FL. Senator Dodd apologizes for not being here to welcome Dr. Flitcraft, but we all have other committees meeting at this moment. We will go to you, Dr. Flitcraft, first.

STATEMENTS OF ANNE H. FLITCRAFT, NEW HAVEN, CT; JOHN WALLER, DETROIT, MI; AND, JORDAN I. KOSBERG, TAMPA, FL

Dr. FLITCRAFT. Senator Hawkins and members of the subcommittee, since 1972, over 700 shelters for battered women have opened their doors in the United States. These shelters have largely been started by battered women, for battered women; they are a grassroots movement. They arise from the community. And I would like to suggest that it is that movement of battered women that has brought the issue of spouse abuse and the issue of family violence in general to our attention today.

In fact, one can trace Dr. Koop's own interest in the domestic violence issue along these same historical lines. So, in fact, we owe a debt to these women who have come forward and organized communities of support for our own presence and participation in the Leesburg Conference and these hearings today.

The scope of the problem of domestic violence and particularly violence against women is, of course, vast. As Senator Dodd mentioned, one in five American women have experienced violence at the hands of an intimate. You can see the same kind of significance in emergency services where similarly one in four or one in five women come in with injuries sustained at the hand of a violent intimate.

Because battering is not a single episode but it is a pattern of abuse repeated over and over again, the disproportionate number of injuries in emergency room services due to battering can reach 40 percent of all injuries brought by women over time.

This means that domestic violence accounts for more injuries to women than street crimes, rapes, muggings, and motor vehicle accidents combined. It is the single largest cause of injury to women in this country. Unfortunately, though, as staggering as this statistic may be, battering is not simply physical injury. The ongoing, repetitive nature of the violence at home coupled with the inadequate services available to injured victims early on leads to an entrapment of victims both within their homes and in isolation from resources in the society in general.

This combination, then, of entrapment and isolation, I suggest, leads to the high rates of alcoholism, drug addiction, suicide attempts, abuse of licit drugs among battered women and their increasingly complex psychological and psychiatric problems that are presented to a variety of care providers throughout the health and social service system.

Similarly, it is this pattern of entrapment and the failure of early interventions that puts their children at risk of child abuse from the hand of the same violent male. I think if we stop for a moment and think about the pattern of abuse and its consequences for individual women, you can realize that the cost is staggering in human terms, in terms of the cost to health and hospitals and the social service system in general.

Battered women come from all walks of life, all social groups, and the profile of the typical batterer resembles all too much that of the typical American male. So prevention and intervention then must begin to question some of the fundamental premises of the society at large. Prevention begins with full protection of the victims and the empowerment of victims.

More fundamental change is necessary in the widespread cultural norms that would view violence against women as a legitimate means of asserting male authority. In concrete terms, then, the recommendations from the spouse abuse prevention committee and the spouse abuse intervention group at the Leesburg Conference felt that domestic violence prevention programs should be developed by Federal, State, and local educational agencies at all levels. This means primary schools, junior high and high schools, community colleges, and universities must begin developing curriculum that concerns domestic violence.

Specifically, this curriculum must look to the causes, dimensions, consequences, and responsibility for interpersonal violence, must continue to note the relationships between power, control, gender stereotypes, sex roles, and ongoing violence, and to begin to develop the skills necessary for nonviolent resolution of interpersonal conflicts.

But a school curriculum or an education-wide curriculum is obviously not sufficient to reach the wider public population that desperately needs education. In view of that, the committee went on to recommend that national leaders in the health care sector, political leaders, the business community, the religious community, culture, and the professions generally should declare their opposition to spouse abuse and woman battering and furthermore go on to develop and distribute appropriate educational materials to their constituencies.

The major components of prevention, then, are identification of the victims, the protection, stopping the violence, expanding the options, and the empowerment of women. We would go on to suggest that in health and social service settings, spouse abuse terms should be uniform in referring to social partners. Regardless of gender or marital status between the victim and the perpetrator, services and resources should be available.

Furthermore, protocols for identification and intervention must be developed in primary care settings in social services generally and not simply emergency settings. But because of the important

sequellae of domestic violence—that is, the alcohol abuse, drug abuse, child abuse, and psychiatric problems—that programs in existence that treat abusers of alcohol and drugs, and so forth, and the high risk populations of child abuse must begin to reorient their programs to identify family members that are victimized by violence and to provide resources to those family members.

Social and economic opportunities such as pay equity, the enforcement of child support orders, adequate low-cost housing, child care, and job training opportunities for women must be increased both before and after abuse is identified. Acknowledging our debt to the battered women shelters and the necessity of the shelter movement as basically the only forum we have to provide immediate protection for abused women, the shelter movement should be extended to meet the emergency needs of victims, including protection, housing, and advocacy.

Criminal justice procedures must ensure that battered women have equal protection under the law. In this context, sexual assault, including rape, should be acknowledged as a crime regardless of present or past marital relationships. Similarly, I call your attention to a recommendation in the full report that Congress needs to address the needs of families living on exclusively Federal jurisdiction properties, for these families fall outside the purview of any presently adequate legislative sanctions against domestic violence. The Federal legislature is the place where that kind of remedy can take effect.

Finally, it is time to acknowledge, as we acknowledge the debt that we owe to those persistent women who have prompted this issue to our attention, it is only through an integrated approach and through the public sphere and the private sphere, through a coalition of law, medicine, education, and social services in general that we can restore equity to the population, particularly those of women, and ensure the right to safety for all our constituents. Thank you.

Senator HAWKINS. Thank you. Dr. Kosberg, we will go to you now.

Dr. KOSBERG. Thank you. Madam Chairman, I am very pleased to be here to discuss with you the problem of elder abuse. To play on words a bit, knowledge of elder abuse is still in its infancy,and we are truly learning more and more about the problem every day.

Before I begin, I would like to acknowledge that, first of all, most elderly live independently and wish to live independently. Most families that do provide care for the elderly provide effective and humane care to elderly relatives. However, elder abuse by family members, friends, and neighbors does occur. It is estimated that between 500,000 and 2.5 million cases of elder abuse occur each year. As opposed to child abuse, for which it is estimated that one-third of the cases are detected and reported, it is estimated that one of six cases of elder abuse are detected and reported.

The problem, indeed, is very invisible. It is invisible because it is unreported by those who are abused. There are many reasons for their failure to report the problem. One of the prevalent reasons, it is believed, is the fact that the elderly fear that the solution to the problem of abuse will be worse than the problem itself, which is to suggest that they fear being institutionalized.

Another reason for the invisibility of the problem is because it is undetected by the general public and by professionals alike. Professionals too often accept at face value explanations given for an elderly individual who has a bruise or otherwise shows signs of adversity.

A third reason is because abuse of the elderly is hidden from outside scrutiny and surveillance. It occurs most often within the confines of the home and therefore is not available for public detection. Physical abuse is one of the types of acts which are included in elder abuse along with psychological intimidation, active and passive neglect, denial of basic rights, and financial and material theft or misappropriation. No group is immune to the possibility of elder abuse.

To make my explanation brief, I would simply suggest that some family members should not be care providers for ill, vulnerable, dependent individuals. Second, other family members, well-intended, often engage in abusive behavior because of excessive pressures and demands placed upon them in the care of an elderly relative. And, indeed, family care in our society is viewed as a panacea, and those in the health care field, social service field, or in the legal system turn almost instinctively to the elderly's family without any assessment as to their appropriateness to provide care for impaired elderly or what the consequences of caring for an older person will be on the family constellation.

What our workshop on elder abuse proposed—very simply—was the greater detection of the problem of elder abuse, the assessment of potential care providers for impaired, vulnerable elderly, community resources to help families care for the elderly, as well as create alternatives for family care, additional research to know more about the prevalence, incidence and the dynamics of elder abuse, and education to educate and train the general public and also those in the helping professions.

And, finally, it must be realized that abuse of the elderly can be in many instances a result of ageism in American society. Also it is a part of the larger social problem of violence in contemporary American society. Thank you.

Senator HAWKINS. Thank you, Doctor. Dr. Waller.

Dr. WALLER. Thank you, Madam Chairman and members of the subcommittee. First, as a public health official, I think I can speak for my colleagues. We applaud Dr. Koop's foresight and leadership in convening this workshop on violence and putting it squarely in the field of public health. We also are privileged to testify before this committee.

By putting the focus on public health, we have the opportunity to use one of the basic disciplines of public health, and that is epidemiology to look at the distribution of interpersonal violence in our population and the opportunity to see where there may be opportunities to prevent interpersonal violence from occurring.

The most definitive outcome of interpersonal violence is homicide, and the workshop that I was privileged to chair dealt with assault and homicide. Homicide accounts for about 23,000 deaths each year in this country. It ranks 11th among the leading causes of death in this country, but it is the 4th leading cause of death for black men 15 to 34 years of age.

Nonfatal assaults may be an even more important problem. The ratio of reported assaults to homicides may be far greater than 100 to 1. Epidemiologic analysis and prevention can substantially change a situation that now exacts such a high toll in morbidity, that is illness, mortality or death, disability, and the quality of life.

Our workshop made some recommendations which go beyond the capacity of the Office of the Surgeon General or health care professionals acting alone in dealing with interpersonal violence. However, it was our opinion that there were some broader policy social issues that cannot be left out in any discussion concerning the prevention of homicide or assaultive behavior.

Therefore, we recommended a Federal ban on sale, manufacture, importation, and possession of handguns and other lethal weapons. We also recommended criminal penalties for possession of a weapon where alcohol is sold or served. You raised the question earlier, Madam Chairman, about the effect of alcohol in interpersonal violence. Although the data is not in and there is nothing conclusive to say that it is causal, there is much evidence to suggest that alcohol and the use of drugs is an integral part of violent acts. For instance, victims and perpetrators of homicides in over 50 percent of the cases for both the victim and the perpetrator there is evidence that alcohol was involved.

We also recommended that full employment issues be discussed and special emphasis for creating jobs for high risk youth be considered. We, as other workshops, discussed the role of television and the media, and we felt there should decreasing portrayals of violent role models in the media, and conversely we should have more presentation of more nonviolent behavior models in the media.

We also suggested that we have to find a way to decrease the cultural acceptance of violence by discouraging corporal punishment in the home, by forbidding it in the schools, and abolishing capital punishment by the State. The rationale for these recommendations is that all of these are sanctions of violence in our society.

We further recommended that the Public Health Service encourage improved training in the identification, treatment, and management of assault and homicide victims in medical schools, nursing schools, social work schools, schools of osteopathy, and other professions that deal with human service agencies.

We also recommended that the Public Health Service facilitate the collection of data on victims of assault and homicide who have contact with the health care system and link those data systems with those from the criminal justice system and the social service agencies. We have those that are trying to begin to do some research in this area who often run into an inability to link those data sets for legitimate reasons of confidentiality of data, but I think that there are ways to move the public good to know more about how we can intervene in these areas without destroying the confidentiality of the persons involved.

We also recommended that the research that the Federal Government funds begin to show a priority for research in homicide prevention equal to the kinds of diseases that are in the 10 leading causes of death. We think if homicide ranks fourth in some risk

groups in our country, it ought to get similar attention in prevention and research as cancer and heart disease. I thank you.

Senator HAWKINS. Thank you, Dr. Waller.

Dr. Flitcraft, I understand a very high percentage of obstetrical patients are abused women. Are battered women more or less likely to be beaten when they are pregnant?

Dr. FLITCRAFT. It is true that a pregnant woman is more likely to be battered. A woman who is battered is more likely to be beaten when she is pregnant. I think that the practical implications of this in terms of programs simply underscore the importance of instituting identification protocols throughout the health care system and not simply in the emergency room.

Senator HAWKINS. That was one of my questions. Should spouse abuse protocols be expanded to other medical settings and not just emergency rooms?

Dr. FLITCRAFT. I think the ones that are probably most interesting and most fruitful to pursue are those in the primary care obstetrical services, on the one hand; on the other hand, to introduce similar protocols on the more complex situations, those of child abuse, for instance, that you have a whole team dealing with the abused child and yet that team does not consider simultaneously the abuse of the mother.

Similarly, you have women in intensive alcohol treatment programs, but those programs do not address the battering that she has received over the years, which has precipitated her addiction to alcohol. So I think those two extremes represent programs where model programs could most readily be introduced.

Senator HAWKINS. Are Americans willing to accept those numbers and those facts?

Dr. FLITCRAFT. Generally, in terms of the widespread nature of wife abuse? I think acceptance involves the legitimation. To accept those statistics means to see that those statistics are legitimated and reflected in program priorities. And I think if those of us who have access to resources—what we have found is when you start offering resources to abused women, more than you ever thought were out there end up on your doorstep. I am sure your experience is the same. That reconfirms, I think, the validity of the statistics.

Senator HAWKINS. When battered women seek assistance medically, is the help they seek for the actual battery or the other medical problems associated with the abuse such as depression or anxiety or nontrauma care?

Dr. FLITCRAFT. I think at this point, unfortunately, battered women continue to be invisible within the medical system. Regardless of whether they come to the emergency room with a black eye or whether they come to the psychiatric service with a suicide attempt, by and large they are not identified as victims of abuse, and the immediate problem; that is, the black eye or the suicide attempt is the only point of medical care.

Senator HAWKINS. What kind of long-term medical or psychiatric problem is the battered spouse likely to develop?

Dr. FLITCRAFT. I think you can think of battering in stages. On the one hand, there is a period of time when physical abuse and continued physical abuse is the primary hallmark of battering. After that time you see a lot of development of minor psychiatric

and minor medical problems, complaints about headaches, and so forth, which are poorly dealt with in the medical care system. And then you see a final evolution of alcoholism. About 1 in 5 battered women go on to be alcoholics; the abuse of drugs, both licit and illicit which may involve as many as 1 in 10 battered women. One in four battered women attempt suicide attempts. One in ten report that their children are at risk for abuse.

Senator HAWKINS. I think the public has the perception that a battered woman is a helpless victim. Is there a personality profile of a battered woman?

Dr. FLITCRAFT. No; and I think it is important that you raise this point. From all the evidence that we can gather, prior to the onset of abuse battered women are indistinguishable from nonbattered women. Their socioeconomic status, their level of education, who they marry, what their family histories are are largely indistinguishable. There is some small number who come from environments where they were abused as children. There is some small number who were addicted to alcohol before they began to be abused. But neither of those factors begins to address the extent of the problem.

Senator HAWKINS. There is a vote on and they are enforcing the 15-minute rule. You can be excused at this time, Dr. Flitcraft, if you would like to. I have some questions from Dr. Kosberg and also Dr. Waller. If you would patiently wait 10 minutes, I will be back.

My staff has suggested we finish it up in 7½ minutes.

Dr. Kosberg, could you tell me, you said abuse to the elderly is rampant. Is that done in nursing homes? Is the abuse done on the street? Is it done in families?

Dr. KOSBERG. Well, first of all, I would not characterize the problem of elder abuse as rampant. As I premised my statement, most family care of the elderly is very decent and very effective. We truly do not know the prevalence of the problem, and that is why our——

Senator HAWKINS. Aren't you doing some research at the University of South Florida on this?

Dr. KOSBERG. Indirectly. We are talking about family pressures and tensions rather than elder abuse pure and simple. So that would be one of the responses.

I should point out that elder abuse is defined as adversity perpetuated by members of the informal care system, which include family, friends, and neighbors, which is distinct from maltreatment within institutional settings as well as crime on the street and in the homes by strangers. Those of us doing research in this area have purposely trichotomized the victimization of the elderly into these three areas because we feel that there are separate dynamics in the cause and consequences of adversity in these three different situations.

Senator HAWKINS. Do you have enough evidence yet to support the need for respite care? We have a bill pending that would allow those that have to tend the elderly 24 hours a day to have a day off, one 24-hour period away, and they could take their care for the elderly down to a center someplace if they are mobile; if they are not, someplace else. Is that good prevention in light of the facts we now have?

Dr. KOSBERG. Indeed, it is excellent. And certainly, to my way of thinking, if there is any one program or service which is greatly needed in the United States, it is respite care which would relieve families of the often unrelenting, 24-hour-a-day care which is needed by family members so that they can take long weekends or holidays and then go back to that caring role which they desperately and dearly want to provide. Yes, it is greatly needed.

Senator HAWKINS. Thank you.

Dr. Waller, you are to be commended for being involved in prevention. The National Center for Health Statistics compiles homicide statistics. Why?

Dr. WALLER. Well, the compilation of homicide statistics is easy to collect. I guess it is the most reportable act of interpersonal violence that we have, and it is forced to be recorded by the criminal justice system, and it is easily shared in fairly reliable reporting. As we began to look at homicide for an opportunity to prevent homicide, those occurrences, where they occur, the setting in which they occur, whether it was family, which accounts for about one-third of all homicides, or whether it was with friends and acquaintances, which would account for about two-thirds of all homicides, those are important kinds of information if we are going to look for opportunities to intervene prior to the act of homicide.

Senator HAWKINS. Are you familiar with the Boston Youth Project?

Dr. WALLER. Yes.

Senator HAWKINS. Has it proven effective in your mind as an expert?

Dr. WALLER. Well, I thik it is a little early to tell. It is promising, and the evaluation component of that project is currently being done. But, intuitively, I believe that the project is going youth ways of dealing with conflict resolution and how to handle their anger.

Senator HAWKINS. We thank those witnesses that appeared today. This subcommittee does have jurisdiction over the Family Violence Act, the Child Abuse Prevention and Treatment Act, and the Children's Justice Act.

We appreciate your participation in the Surgeon General's workshop and you being able to help us. I look forward to working with you on some of the solutions as you proceed. Thank you very much.

[Whereupon, at 1:10 p.m. the subcommittee was adjourned.]

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